BARRIERS AND INROADS TO AIDS DIALOGUE
IN THE AFRICAN AMERICAN CHURCH:
DEVELOPMENT OF A STRATEGIC MODEL AND TOOL FOR NETWORK
DIFFUSION OF ABSTINENCE-BASED HIV PREVENTION ADVICE

By

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This study is dedicated to the memory of Allen L. Bunch, 1951-1997.

Allen's long fight with AIDS gave him the opportunity to motivate and uplift those around him, even the least fortunate, and it fueled his vision for founding the African American AIDS Task Force in Gainesville, Florida. His compassion toward fellow African Americans gave him the courage to share his testimony of rising from hopelessness and despair to finding a reason to live through helping others. It is hoped that this study will further Allen's dream of empowering the African American church to overcome its fears and denial, so that it can warn its youth about the dangers of AIDS and embrace those who suffer and place themselves at risk of HIV infection. While the family and friends Allen left behind continue to carry on his mission, he always will be dearly missed.

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While AIDS rates among many groups have leveled off or declined in recent
years, African Americans continue to be disproportionately diagnosed with the deadly
disease. They constitute nearly half of reported AIDS cases in the U.S. but only 13
percent of the population. The black church has great potential for HIV prevention,
despite religious stigmatism, because the institution is a touchstone for extended families.

The objectives of this exploratory study were to modify existing health behavior
theory, develop directions for future research about culturally specific, church-based HIV
prevention strategies, and to reveal factors that block or empower constructive AIDS
dialogue in these settings. The qualitative study included 10 groups of focus group
interviews with 85 lower-income adolescents and women, 13 in-depth interviews with
clergy, church members, and AIDS organization leaders, and participant observations of
events within AIDS organizations and churches.

Adolescents collaboratively developed skits and "raps" for a photo-illustrated comic book that was used as both an HIV prevention tool and as a device for gathering information about how individuals engage in AIDS dialogue in religious contexts. When participants shared these booklets with others, the outcomes included initiation of AIDS dialogue, enthusiasm, momentum, ownership, increased self-efficacy, and intent to maintain of healthy behaviors.

The data revealed contexts, opportunities, and benefits of AIDS dialogue, as well as popular and prescriptive norms of AIDS knowledge and attitudes, health beliefs, religiosity, sexual behaviors and scripting, substance use, and source credibility. An organizing theoretical framework consisted of eight domains: predisposing and environmental factors, message design and delivery, cognitive and normative processes, enabling factors, potential barriers, and outcomes.

Clergy were blamed for prohibiting AIDS dialogue. However, many women viewed themselves as "torch bearers" of HIV prevention in church settings, community sentinels, surrogate parents, and counselors. AIDS dialogue can be stimulated in religious contexts through interpersonal interventions sensitively tailored to address condom use, AIDS stigma, homosexual behaviors and other religious taboos, while utilizing Christian principles such as evangelism, prayer, behavioral accountability, and divine guidance.

CHAPTER 1
INTRODUCTION

The early sunlight streams through the sprawling oak trees lining the sleepy downtown streets of a Florida town. Donning a lacy, emerald-green pillbox hat this humid Sunday morning, a young mother makes her way toward an old strip mall. Once housing several African American stores near the town's "red light" district, better known as "Porters Quarters," it is now rented to an inter-denominational, African American church. The woman hugs several elderly friends at the door of the worship center, and she finds her seat among the rows of metal folding chairs.

A worship team draped in golden satin robes hums a lively spiritual in three-part, a cappella harmony. A minister wearing tasseled vestments rises to greet his congregation, shouting words of encouragement: "I went to the rock to hide my face. The rock cried out, 'No hiding place!'" Amid a sea of fluttering paper fans – each displaying a funeral home ad and scripture – the congregation begins a refrain of "Amazing Grace."

Just outside the church door, a homeless man stumbles down the sidewalk clutching a wine bottle in a crumpled brown bag. A thin, disheveled woman in spike heels emerges from a dilapidated house. Three men lounge on the concrete steps of the corner plasma donation center, sipping malt liquor and setting up "shop" for the addicts who come to sell their blood for drug money. In a nearby low-income apartment, young teens hang out just to "make out" and watch a sex movie on cable TV, at least until Momma comes home from church.

Sheltered within the sanctuary, with windowless walls bearing bright banners and activity calendars, the church members don't whisper about the goings on outside – the prostitution, drug addiction, drinking, teen sex, homelessness, despair. The worlds of sin and worship, for the moment separated only by the graffiti-covered paneling of the strip mall, do not collide even when the smiling churchgoers venture to their cars and drive back home for Sunday dinner.

As the weeks and months drift by, a deadly virus spreads silently through the black community's social networks of friends, families, lovers, and victims of abuse. Within the churches, believed to be resources of hope, healing, and salvation, the ministers and their cloistered churchgoers do not speak of HIV nor express concern that their own children and grandchildren might be vulnerable to the dreaded disease.[1]

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[1] This narrative is a composite of the investigator's observations of neighborhood activities, worship participation in three different churches in the African American community, and anecdotal evidence corroborated by key informants.

Overview

Although the African American church as a whole still denies the severity of the AIDS epidemic in the black community, as will be shown, the institution stands as the cornerstone of the extended family and has more potential than any other organization to mobilize activism in addressing social ills of every description.

The primary purpose of this qualitative study was to explore the factors that can enable and inhibit constructive dialogue about AIDS prevention in the African American community. A major goal was to develop strategies for promoting AIDS dialogue among younger adolescents and adult female opinion leaders, within a context that is sensitive to the religious norms of the church.

Problem

Public health experts speculate that at least a million Americans are infected with human immunodeficiency virus (HIV), a virus believed to weaken the immune system and lead to the diagnosis of a terminal, infectious condition known as acquired immunodeficiency syndrome (AIDS). In the United States, 581,429 cases of AIDS were reported between 1981 and 1996, and 62 percent of those individuals have died (CDC, 1996). Since the mid-1980s, when the number of reported cases began to increase exponentially, many authorities have regarded AIDS "as the greatest health crisis of our era" (Treichler, 1988, p.195).

In 1997, the AIDS rate was seven times higher among blacks than among whites (UPI, 1997). The disproportionate infection rate among blacks became acute in 1993

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when the CDC reported that 55 percent of all new AIDS cases were among blacks and other minorities. As of June 1997, African Americans constituted 38 percent of all reported AIDS cases in the U.S. (CDC, 1997), but in total numbers constituted 13 percent of the population (U.S. Bureau of the Census, 1997). Every hour, one African American child or teen dies of AIDS and one contracts HIV somewhere in the United States. Six in 10 children born with HIV, and half of all intravenous drug users with AIDS are African American (HERO, 1994).

The sexual routes of HIV transmission are vaginal and anal sexual intercourse and oral sex, both fellatio and cunnilingus. AIDS is transmitted non-sexually through perinatal transmission, sharing infected needles, sharing toothbrushes or razors, blood transfusions, and the use of infected clotting factor or other blood products. HIV is not transmitted through insect bites, sharing dinnerware, blood donations, food handling, hot tubs, or saliva, nor through "casual social contact such as shaking hands, hugging, social kissing, crying, coughing, or sneezing" (Surgeon General, 1986, p. 21).

The prospects for a cure or vaccine still are remote, but risky behavior among Americans appears to have increased recently because of the discovery of increasingly effective AIDS treatments. While AIDS deaths rates have leveled or declined among most groups, public health leaders have called for rededication and reconceptualization of HIV prevention efforts because the virus continues to spread (Lifson, 1994). Although some believe that AIDS education has failed (Philipson, Posner & Wright, 1994), the first decade of the epidemic has shown that lasting behavior change can occur as the result of carefully tailored, targeted, and persistent prevention efforts (Stryker, Coates, DeCarlo, Haynes-Sanstad, Shriver & Makadon, 1995).

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Currently, the only means of slowing the spread of the virus is public information and education. The effectiveness of an AIDS campaign lies in its ability to modify AIDS-related attitudes, beliefs, and behaviors (Ross & Rosser, 1989). During the 1980s, televised public service announcements were used to try to change audience attitudes and behaviors about drug use and to change sexual practices (Gentry & Jorgensen, 1991).

Although these PSAs have been helpful in delivering general information to general audiences (Hastings, Eadie, & Scott, 1990; Blosser & Roberts, 1985), the general consensus of researchers is that such mass media campaigns alone exert limited influences on audience behaviors (Gantz, Fitzmaurice & Yoo, 1990).

Some argue that the greatest benefit of mass mediated health messages is the fact that these messages raise the public's awareness of health-related issues (i.e., Gantz, Fitzmaurice & Yoo, 1990; Lau, Kane, Berry, Ware & Roy, 1984). However, knowledge alone is not sufficient to inoculate individuals against risk taking because intellectual appreciation of risk does not necessarily translate into sustained behavior change, particularly for activities as inherently pleasurable as sexual intercourse (Stall, 1994).

AIDS is still generally considered a "bad" disease carried by "bad" people. AIDS prevention efforts continue to be limited by a widespread unwillingness to explore and frankly discuss sexual and drug use behaviors, including homosexuality, teen sex, condom use, oral and anal sex, injection drug use, prostitution, and promiscuity. These discussions are constrained by political considerations, law, and concerns about morality, and many people do not personally identify with the disease because they do not know anyone who is infected. These attitudes contribute to denial of personal risk, misperceptions about transmission, and discrimination against people with the disease or

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groups identified as high risk (Williams, Scarlett, Jimenez, Schwartz & Stokes-Nielson, 1991).

African Americans and other ethnic minorities have suffered disproportionately from HIV infection over the past 15 years. Public health officials began to take notice of this trend in 1993 when the U.S. Centers for Disease Control reported that 55 percent of all new AIDS cases were among minorities and that the AIDS per capita rate among African Americans was more than five times higher than the national rate (CDC, 1996). As of 1996, African Americans constituted 37 percent of all reported AIDS cases in the U.S. (CDC, 1997), but in total numbers constituted 13 percent of the population (U.S. Bureau of the Census, 1990). By 1997, the AIDS rate was seven times higher among blacks than among whites (UPI, 1997).

Although black women account for 13 percent of all women (U.S. Bureau of the Census, 1997), they account for nearly 60 percent of all AIDS cases among women (CDC, 1996). In 1996, black women were 15 times more likely than white women to be diagnosed with AIDS. African American males were nearly five times more likely than white males to get AIDS (CDC, 1996), even though there were seven times more white males than black males. Black males accounted for 12 percent of the U.S. male population (U.S. Bureau of the Census, 1997).

Identifying specific cultural elements that predict the effectiveness of HIV prevention programs and individual receptivity to prevention messages is a critical task for health communication researchers (Stryker, Coates, DeCarlo, Haynes-Sanstad, Shriver & Makadon, 1995). The need for cultural sensitivity in delivering HIV prevention messages has become increasingly recognized by both scholars and public

health practitioners (Bayer, 1994). For example, Nyamathi, Leake, Flaskerud, Lewis, and Bennett (1992) found that presenting basic, culturally-relevant information alone can reduce high risk behaviors among impoverished African-American and Latina women participating in AIDS counseling programs. Hecht, Collier, and Ribeau (1993) argue that prerequisites for cultural sensitivity are communication competence and an understanding of African American ethnic identity and cultural variation, not just an understanding of normative or otherwise "typical" behaviors among African Americans.

Rationale

Jones (1995) notes that the church is "the only indigenous institution" in the black community (p. 16). The primary formal and informal sources of assistance to individuals in the black community are churches, social clubs, and community organizations (Spector, 1991). The interconnectedness of these groups and social support networks has important implications for risk behavior assessment and prevention (Gleaton & Johnson, 1995). Because of the pervasiveness of its religious norms within extended families and other social networks, the church has the potential to create the kind of cohesive atmosphere needed to carry out an effective AIDS prevention campaign.

Less education and low self-esteem among many African Americans, combined with fundamentalist religious beliefs common among members of most African American churches, tend to promote disapproval of sex education, condom distribution, or even discussion about AIDS. In addition, this disapproval, fear, and denial can contribute to a community environment of stigmatization, condemnation, and irrational fear of AIDS.

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African American adolescents are the target of a trial AIDS intervention in this study. However, the majority of African American youths across the U.S., with the exception of those in the South, are not committed to the church (Taylor, 1988). Many younger blacks who drop out of church feel the pastors of black churches are hypocritical and do not live up to their call as ministers (Trout, 1989). Others question the necessity of church because their fathers do not attend or because they feel that going to church is not a measure of religiosity (Moore & Waiters, 1995).

Despite these barriers, the unifying and empowering force of the church within the entire black community may justify attempts to provide some form of AIDS education that is grounded in church values and disseminated through social networks that have church-related linkages. Further, the church's ability to reach out to at-risk youth is highlighted by the fact that most black youths believe in God and Biblical teachings even if they do not attend church regularly (Moore & Waiters, 1995), and most are part of an extended family whose elders are highly religious.

The black church serves as a touchstone among both religious and non-religious individuals. It has a long and distinguished tradition of leading and caring for its people in times of great suffering. Often it has served as an impetus for education and change in times of crisis through pastoral activism and church mobilization. Many sociology and history scholars have argued that the Civil Rights Movement of the 1960s was born and sustained through the collaborative efforts of black churches (Findlay, 1993). The spread of activism, such as the black student sit-ins, followed the networks of black churches in the South (Morris, 1981). Many black churches also hosted informal grassroots academies that were crucial to the development of the movement (Edwards & McCarthy,

1992). Because of this high level of activism, many black churches today still confront a variety of nonreligious community crises and thus maintain a dynamic tension between the spiritual and social missions of the church (Burris & Billingsley, 1994).

In exploring individual beliefs, environmental factors, and social norms, this study used iterative and ethnographic methods to design AIDS prevention messages that are acceptable within African American church settings. The messages show who is vulnerable and why, promote personal control in AIDS prevention, provide information about HIV transmission, show that the AIDS threat is local and close, offer strategies for interpersonal communication about AIDS, and account for peer-group influence.

Objectives

This study was intended to examine a complex tapestry of interwoven factors, as suggested by a synthesis of existing behavioral theory, previous empirical studies, and sociological studies of the African American community. Of particular interest were the predisposing, environmental, cognitive, normative, enabling, barrier, and message design variables that can influence the effectiveness of an AIDS prevention message that is bounded by cultural and religious sensitivities and that targets African American youth, a high-risk population.

To that end, the study utilized an original, collaboratively created *fotonovela* (photo-illustrated comic book) as a discussion tool to help the research participants articulate their views about AIDS prevention and to stimulate AIDS-related dialogue among youths and women in everyday, "real-life" settings. In light of known literature, this study is the first to develop a *fotonovela* that targets African Americans with a health promotion message.

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An original conceptual framework synthesized major behavioral theories that have been used to predict compliance with health promotion advice. This model subsequently was used as an organizing framework to contextualize themes that emerged from transcript analysis, to use these findings to modify existing theory, and to construct grounded theory.

A triangulation of qualitative methods – a battery of long interviews, two years of participant observation, and a unique, multi-stage focus group design – facilitated the collection of data about cultural factors that inhibit and facilitate AIDS prevention efforts within various religious contexts. This information provided an understanding of how various risky behaviors are perceived by the African American religious community and mediated by social relationships within this culture. In addition, this study explored group norms, individual values, and cultural beliefs about the realities and acceptability of unsafe sexual behaviors.

The primary research questions of this study were

1. What are the specific inroads and barriers to AIDS-related dialogue among African Americans within various religious contexts?

2. What are the processes by which African American women and youth could engage targeted youths in discussions of AIDS issues, and in what settings does this kind of dialogue occur?

3. How could group construction of an original *fotonovela* and the subsequent group evaluation of this tool be used to assess attitudes, beliefs, and new ways that AIDS-related dialogue could be facilitated within existing social networks among African American youth and women?

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4. To what extent could this *fotonovela* change individual attitudes about HIV and the risks associated with unsafe sex?

5. How effectively could a *fotonovela* promote self-efficacy by offering strategies for postponing sexual involvement, parent-child interaction, partner negotiation, resisting peer pressure, building self-esteem and personal responsibility, teaching decision-making skills, and setting life goals?

6. Among African American youth, what factors serve as barriers to their postponement of sexual involvement or sexual abstinence?

7. What kind of AIDS prevention advice would best legitimize sexual abstinence for teens and empower them to comply with this advice, in a manner consistent with both their social norms and religious norms rooted in church theology?

8. Which strategies could overcome barriers to HIV prevention, including denial of threat and other attitudes that inhibit rational decision-making?

Overview of Chapters

Chapter 2 is a literature review organized by a theory synthesis model that shows the relationships among basic components of health behavior change theories. The discussion of existing literature is related to various domains and theoretical constructs of the model, and it serves as a point of departure for theory development and modification in later chapters.

The literature review discusses theoretical concepts of the model both in light of individual and cultural contexts. The eight domains of the model are predisposing and environmental factors, behavior change message components, cognitive and normative

processes of health behavior, enabling factors and potential barriers to action, and behavioral outcomes.

Prior research about health communication and campaign theories includes literature about Diffusion of Innovations, Social Cognitive Theory, Theory of Reasoned Action, Health Belief Model, Parallel Processing Model, and other theories. The discussion also addresses AIDS epidemiology among African Americans, social marketing strategies, use of a *fotonovela* as an alternative micro-media campaign channel, opportunities for abstinence-based HIV prevention, the structure of the black community, religiosity among African Americans, barriers to AIDS prevention, and opportunities for AIDS activism in the black church.

Unlike many studies that are designed to test the stability or generalizability of one particular theory, this study addresses many issues and synthesizes a number of related behavior change theories. This broader approach offers an exploration of higher-level theory, via an integration of variables and other concepts from numerous middle-range theories. Zucker, Aronoff, and Rabin (1984) lamented that in most behavioral studies, researchers merely

> Take manageable problems, apply a middle-level theory for the portion of human behavior related to that smaller realm, collect data on easily available (college student) respondents, use the results to fine tune the theory, and then move on to the next middle-level problem. (p. 1)

Maddi (1984) similarly contemplated this issue:

> It is fashionable . . . these days to restrict conceptual effort to the middle ground, in the belief that the grand theories of the recent past are impediments to scientific advance . . . An unfortunate feature of a commitment to middle-level theorizing is the general distrust of any formulation that appears to have any surplus meaning . . . This leads readily to reliance upon single explanatory concepts, which appears so parsimonious but really turns out not to be, as we

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must add more constructs each time we do another study. . . . Once one recognizes that the various concepts in a comprehensive theory influence each other as to meaning, it becomes less surprising that a concept called by the same name in two different theories may have somewhat different connotations. (pp. 26, 32)

In addition to exploring attitudes and behaviors of harder-to-reach populations using an integrated conceptual framework rather than a single middle-level theory, the present study also was designed

1. To build new theory, as well as to evaluate and modify existing theory.

2. To explore a rich and complex matrix of cultural factors of the research participants through the development of a conceptual framework that shows relationships among various facets of AIDS prevention targeting African Americans. Michal-Johnson and Bowen (1992) describe culture as a dynamic, multifaceted process that is like layers of transparency film that produce a composite color when illuminated. Applying their metaphor to this study, a goal of building the theoretical model from existing literature was to use it to frame various cultural realities, and to see how these multifaceted realities, in turn, illuminated the limitations of traditional behavior change strategies.

3. To better explain, by showing relationships among culturally relevant concepts, why some individuals within particular cultural groups adopt preventive behaviors while others do not, as well as to predict which types of messages or program strategies could be more effective. Although a general concept of culture is implicit in many traditional health behavior models, most empirical studies that utilize or test these models do not adequately

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explain the specific ways that culture influences various behavioral outcomes (Michal-Johnson & Bowen, 1992).

4. To use an organized synthesis and discussion of existing theory and evidence to help inform the development of a *fotonovela* for use as an AIDS prevention tool for African American audiences versus other types of media that traditionally have been less effective.

Chapter 3 describes the methodology of the study, including a discussion of qualitative communication research approaches, justifications for the site selection, and a description of the research questions and study objectives. The chapter discusses the methods used in the participant observation, in-depth interviews, focus groups, and recruitment of participants. This chapter also describes the procedures involved in developing the *fotonovela*, conducting readability analysis, providing informed consent, in evaluating validity threats, and in transcribing, analyzing, and interpreting the data-texts.

The in-depth interviews included one-on-one discussions with African American clergy, as well as members of a minority AIDS advocacy group, national AIDS ministry leaders, and an African American woman living with AIDS. Teen participants in a summer youth program collaboratively designed and developed a short *fotonovela*. Copies of this story booklet then were distributed to the African American youth and to African American women in a Bible study group in a low-income neighborhood. After participating in a focus group designed to assess AIDS knowledge, attitudes, and beliefs, participants returned for follow-up sessions where they were encouraged to share personal stories about their AIDS outreach efforts and reactions to the *fotonovela*.

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Chapter 4, the analysis chapter, presents a theme analysis of data-texts, and the themes are organized and contextualized using a theoretical framework that synthesizes various behavior change models. Numerous exceptions to this initial framework also are highlighted. This chapter also offers examples that illustrate the meanings, patterns, and contexts in which respondents interpret and discuss AIDS-related issues. The chapter highlights the nature of AIDS dialogue in the African-American church, giving particular attention to the processes by which African-American youth and church-going women engage others in discussion of AIDS issues using a *fotonovela* as a tool.

Chapter 5, the summary and conclusions chapter, discusses the theoretical, methodological, and practical implications of the study, the study's limitations, a summary of key findings, and an agenda for future research. The final chapter also includes a discussion of various barrier and efficacy constructs, as well as implications for future *fotonovela* interventions targeting African Americans. Theme analysis was used to develop recommendations for a church-based AIDS prevention campaign, and to provide insights into AIDS-related attitudes, including religiosity-based barriers to AIDS prevention. The findings also were used to refine the *fotonovela* for future use both as a tool to motivate teens to practice sexual abstinence as well as to foster open dialogue about AIDS prevention issues among youth and between adults and teens.

The Need for Culture-Specific Health Behavior Models

The Health Belief Model, Theory of Reasoned Action, Extended Parallel Process Model, and AIDS Risk Reduction Model provide relevant concepts needed to assess and develop a basic AIDS prevention strategy. However, they are static and linear in their view of the health attitude and behavior change process.

Following the logic of these models, African American adolescents confronted with the threat of HIV infection would be expected to rationally assess personal susceptibility, threat severity, costs, benefits, and the efficacy of the prevention advice. Teens also would be expected to rely on past experiences and knowledge, particularly gained from social interaction, as important bases to make these judgments. From this assessment, the teens would make decisions about whether or not to adopt the recommended HIV prevention action.

These models assume that the decision-maker is a rational individualist who can freely receive information and develop a health decision based on interactions with knowledgeable others. However, since individuals do not always make health decisions based on cost-benefit analysis or objective evaluation of various perceptions, they may instead and more likely choose to comply with cultural or social norms. In addition, many people irrationally discount risks and perceive themselves as invulnerable to harm. The

perception that AIDS is not a threat often might be explained by the typical adolescent's "it won't happen to me" attitude.

Another weakness of these psychosocial models is that they can only account for the amount of variance in health-related behavior change that can be explained by individual health-related attitudes and beliefs. The explained variance is typically 12 percent or lower, possibly because the social and cultural forces that can override rational choice can be stronger predictors of health-related behavior than attitudes and beliefs.

Existing theoretical models also do not fully account for all factors that predict risky behavior or compliance with an AIDS prevention message in every culture. None of these models have fully explained or predicted health behavior in all cultures, likely because they are intended to be generically cross-cultural and thus do not include specific cultural norms that have a powerful influence upon individual health decisions.

Thus, new culture-specific models are needed to expand existing models and/or integrate constructs from existing theories, in order to account for normative barriers to action such as traditional social structures and values. Unlike the broad-based behavior change models, a new model could account for behaviors shaped by habit or addiction, behaviors undertaken for non-health reasons (i.e., for attractive appearance, social approval), or behaviors guided by economic or environmental factors. The intregrated framework used in the present study attempts to synthesize both individual cognitive and normative components, as well as the factors that predispose individuals to various outcomes.

A Strategic Model of AIDS Preventive Behavior Change

The following discussion highlights the rationale and strategies used in developing an integrated theoretical framework for the present study.

A key component of qualitative research design, according to Maxwell (1996), is the conceptual context of a study – "the system of concepts, assumptions, expectations, beliefs, and theories that supports and informs your research… This context, or a diagrammatic representation of it, is often called a conceptual framework." Without the construction of a conceptual framework, he argues, the use of existing theory can "often degenerate into a series of 'book reports' on the literature, with no clear connecting thread or argument" (p. 26). A researcher should develop a conceptual context or framework prior to data collection by identifying theories, literature, and findings that relate to the phenomena being studied (Maxwell, 1996).

A review of relevant prior research can be used to test or modify theories because it can help a qualitative researcher see if existing theory is supported or challenged by previous studies, as well as generate new theory (Maxwell, 1996). Gilgun (1994) notes that many qualitative researchers "usually do a thorough literature review before beginning their research" in order to "survey the field, develop an understanding of what is known, and identify gaps in knowledge, which may give direction to the research." In addition, qualitative research that does not have a basis in existing literature "does not develop higher order concepts and therefore leaves other researchers with little on which to build" (p. 117).

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Howe and Eisenhart (1990) assert that the use of prior research "ensures that qualitative research is rigorous" (p. 2). Similarly, Panitz (1997) argues that standards of rigor include (1) a solid review of existing theory, (2) a presentation of material that either supports accepted theory and/or expands or modifies that theory, and (3) changes to theory that are supported by data.

Miles and Huberman (1994) state that a conceptual framework "explains, either graphically or in narrative form, the main things to be studied – the key factors, concepts, or variables – and the presumed relationships among them" (p. 18). Concept mapping, a similar tool, was developed by Novak and Gowan (1984), and a third variation, called an integrative diagram, was developed by Strauss (1987). Another similar tool is the influence diagram, proposed by Howard (1989).

A conceptual framework consists of concepts and the relationships among them, and these relationships "are usually represented, respectively, as labeled circles or boxes and as arrows or lines connecting them," and the framework serves "to pull together, and make visible, what your implicit theory actually is, or to clarify an existing theory" (Maxwell, 1996, p. 37). The most productive ways of constructing a conceptual context, Maxwell argues, are:

> Often those that integrate different approaches, lines of investigation, or theories that no one had previously connected . . . This framework is something that is constructed, not found. It incorporates pieces that are borrowed from elsewhere, but the structure, the overall coherence, is something that you build, not something that exists ready-made. It is important for you to pay attention to the existing theories and research that are relevant to what you plan to study, because these are often key sources for understanding what is going on with these phenomena. (p. 27)

A key distinction is the difference between variance maps and process maps. Maxwell (1996) notes that variance maps deal with abstract, general concepts and depict how some factors or properties of things (conceptualized as variables) influence others. A process map tells a chronological story, and the categories are presented as specific events rather than as variables.

The Conceptual Framework

The literature review in this chapter is organized using a model designed to explain the relationships among basic components of health preventive behavior change processes, particularly among African Americans, as well as to show how these concepts can be applied to the development of health campaign strategies. Public health campaigns involve numerous factors, ranging from individual characteristics to social system variables (Sheer & Cline, 1994). The model in this study is used to categorize, delineate, and organize a wide range of variables as they relate to relevant theories and empirical evidence in the health communication literature.

The framework is a variance map that shows the relationships among concepts, as well as the causal network of variables and influences upon AIDS preventive behavior among African Americans. The basic model is a network of eight large domains, with a number of sub-categories and properties within each of these domains.

The model in this study is shown in two versions: basic and descriptive (Figure 1 and Figure 2). An iteration of the model introduces each section of the literature review. Although the model is general enough to be applied to health prevention campaigns addressing risks other than AIDS, it is expanded in the literature review to address the particular cultural factors that influence AIDS preventive behavior change among

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African Americans. The logic and physical structure of the model was developed through a synthesis of components from existing theories, concepts, and models.

Michal-Johnson and Bowen (1992) note that the three primary models used in attempts to understand AIDS-related health attitudes and behaviors are Fishbein and Ajzen's (1975) theory of reasoned action, Becker's (1974) health belief model, and Bandura's (1994) social cognitive theory. The theory of reasoned action places more emphasis upon rational decision-making than the health belief model or social cognitive theory, and it is more detailed in specifying relationships among theoretical variables. In addition to these three models, the framework used in this study integrates structural and conceptual components of Ajzen's (1988) Theory of Planned Behavior, Witte's (1996) Extended Parallel Process Model, and the AIDS Risk Reduction Model by Catania, Kegeles, and Coates (1990).

The framework used in this study (shown in Figures 1 and 2) also integrates structural and conceptual components of the following theories:

- Diffusion of Innovation (Rogers, 1995)
- Theory of Planned Behavior (Ajzen, 1988)
- Persuasive Health Messages Framework (Witte, 1995)
- Protection Motivation Theory (Rogers, 1975)
- Input/Output Matrix (McGuire, 1989)
- General Model of Communication (Gerbner, 1956)
- Elaboration Likelihood Model of Persuasion (Petty & Cacioppo, 1981)
- Transformation Model of Communication (Kreps, 1994)
- Stages of Change model (Prochasta & DiClemente, 1984)

The model is intended to serve as a global view of health decision processes, specifically designed for the integration of unique cultural factors for a specific target audience. While it is not a path model showing correlational linkages, the model shows

connections among variables using lines and arrows that illustrate relationships that have been statistically demonstrated in previous health communication studies.

The following discussion provides a summary of each component of the conceptual framework (Figure 1).

Before an individual is exposed to a behavior change message, he or she will be unconsciously conditioned to accept or reject the message depending upon individual predisposing factors and the external factors of his or her environment.

Predisposing factors are components of a target individual's existing intrapersonal-level reality prior to exposure to a preventive health message, and these factors are considered to be antecedents to attitudes and behavior. Psychologists generally have identified intelligence, self-esteem, and sex differences as recipient factors that predict the extent that a person can be persuaded (Petty & Cacioppo, 1981).

The factors that predispose an individual toward AIDS preventive behavior are assumed to include personality factors, needs, demographic factors (age, sex, and education), values (i.e., religiosity), prior knowledge about AIDS transmission, prior experience practicing AIDS preventive behaviors (such as condom use or AIDS prevention negotiations with a partner), behavioral risk factors (homosexuality, teen sex, and drug use, as well as cultural norms – truancy, motherhood norm, and scarcity of eligible black men – that place African Americans at risk), and previous positive health activities such as participation in church-based health interventions.

Environmental factors are the external influences upon individual behaviors that are assumed to exist before a person is exposed to a behavior change message. In this study, these factors include social network norms (including norms within the African

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American community and black church), cultural norms of communication (the African American oral tradition), the structure and norms of African American families, media access and use among African Americans, AIDS epidemiology at the national, state, and community levels, and the availability of community resources, with a focus on the evolution of the African American AIDS Task Force.

It is within the predispositional and environmental context that a *health message* is introduced to the individual, and the manner in which various components of the message are crafted and presented predicts its eventual impact on behavioral outcomes. These components include cues to action, the nature of change agents, homophily and other characteristics of sources appropriate for African American audiences, characteristics of abstinence messages, message strategies including social marketing and community-based health campaign planning, and the selection of channels for targeting African Americans, including the *fotonovela* as an alternative micro-media channel.

After a person has been exposed to a message, he or she will process it within both cognitive and normative spheres before taking action. In other words, a person's inner thoughts and feelings, as well as his or her innovativeness, roles within social networks, and perceived views of important social referents will predict how the person acts on the message.

Cognitive processes – learning, motives, beliefs, and attitudes – are predictive of behavior. In the model, these processes are assumed to be the catalysts of behavior change that are influential after an individual has been exposed to a behavior change message, as contrasted with the effects of predisposing factors. The aspects of learning, which include attention, comprehension, social learning, and sexual scripting, are

assumed to be dependent upon an individual's cognitive competencies. Thus, motives, attitudes and beliefs would be expected to have little influence on intended behavioral outcomes unless learning has first taken place. Sheer and Cline (1994) note that motives are more cognitively fixed, while attitudes and beliefs are more changeable and thus have less direct influence on behavioral outcomes than motives.

The literature review discusses the theoretical components of learning in light of the study – the specific objectives for reaching African American youth with an abstinence-based AIDS prevention message in a *fotonovela* format. This section discusses developmental predictors of attention, processes of reading comprehension, the social learning process, and sexual resistance strategies.

Motives related to health behavior are discussed in light of self-evaluation and social modeling, both components of Bandura's (1994) social cognitive theory. Salient beliefs are discussed in relation to perceived risks and personal relevance, as well as an overview and critique of Becker's (1974) Health Belief Model. The discussion of attitudes focuses on African American attitudes about various health issues, pro-social attitudes promoted by television dramas, and the role of persuasion in community-based AIDS prevention campaigns.

Normative processes are assumed to be the social catalysts of behavior change that influence individuals after they have been exposed to a behavior change message, as contrasted with the effects of environmental factors. These processes are discussed in light of social network applications in prevention planning, diffusion of innovations theory, opinion leadership, and communication networks, as well as theories about behavior norms, social influence, and individual perceptions about salient referents.

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Beyond the cognitive and normative processes of interpreting and contextualizing a health message, a number of factors serve to enable a person to comply with the message or serve as barriers to a recommended action.

Enabling factors include Bandura's (1989) concepts of self-efficacy and response efficacy, and Witte's (1996) process of danger control, as well as source credibility, social support, reinforcement of values through AIDS prevention initiatives in the African American church, and the acquisition of AIDS prevention skills, which is contingent upon educational effectiveness and empowerment.

Potential barriers include racism, black genocide theory, denial, myths and misinformation, taboos, lack of resources, low literacy, poverty, homelessness, family problems, and depression.

Finally, after each variable exerts its effects upon an individual's decision-making process, he or she is expected to act, even if the chosen action is to do nothing at all. From the perspective of the campaign planner, the *behavioral outcome* either will be desirable or undesirable.

The descriptive version of the model (Figure 2) includes a corresponding diagram of Rogers' (1995) diffusion of innovations theory, the primary theory guiding this study, in order to illustrate how the behavior change strategy parallels the diffusion process. Details about the diffusion process are discussed in the "normative processes" section of the literature review.

In this study, desirable outcomes include behavioral compliance – sexual abstinence or the postponement of sexual involvement – as well as lower-level outcomes such as increased interest in AIDS issues, new awareness or knowledge of AIDS risks,

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the strengthening of social support networks for open discussion of preventive behaviors, and the sensitization of adults about the needs and pressures faced by adolescents and new strategies for adult-teen communication about those problems.

Undesirable outcomes might include initiation of sexual involvement, continuing sexual involvement, withdrawal from social support networks, reduced interest in AIDS issues, confusion about AIDS transmission, denial of personal risk, or self-devaluative behaviors, described by Bandura (1994) as the rationalization of self-deplored actions (such as the decision to have sexual intercourse despite internalized religious beliefs that label such behavior as sinful).

INDIVIDUAL PROCESSES

CULTURAL CONTEXT
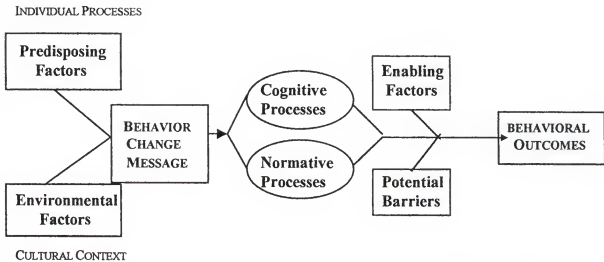
FIGURE 1: A Strategic Model of AIDS Preventive Behavior Change

Predisposing Factors

Personality
Needs
Demographics: Age,
  Gender, Education, SES
Religiosity
AIDS risk factors
  Drug use
  Homosexual behaviors
  Teen sex
  Truancy
  Homelessness
  Racism
  Sex-ratio imbalance
  Motherhood norm
AIDS prevention
  knowledge / experience

Cognitive Processes

Learning   Motives
  Attention   Self-evaluation
  Comprehension   Social modeling
  Social learning
  Sexual scripting   Beliefs
                      Health beliefs
Attitudes   Perceived risk
  About AIDS   Relevance
  Prosocial attitudes

Enabling Factors

Self-Efficacy
Response Efficacy
Danger Control
Social Support
Community Support
Skills Acquisition
Effective Education
Empowerment
Values Reinforcement
Church Intervention

OUTCOMES

Desirable
Undesirable

BEHAVIOR CHANGE MESSAGE

Cues to action
Change agents
Source
  Homophily
  Credibility
Components
Strategies
  Social Marketing
  Channel Selection

Normative Processes

Diffusion process
Opinion leadership
Communication networks
Norms
  Behavior norms
  Popular norms
  Prescriptive norms
  Social Influence
  Salient referents

Potential Barriers

Lack of self-efficacy
Black genocide theory
Denial
Fatalism
Lack of cultural relevance
Myths & Misinformation
Cultural Taboos

Environmental Factors

AIDS Epidemiology
Community Resources
Media Access & Uses
Social Network Norms
Church Norms
Communication Norms
Family Structure/ Norms

Innovativeness   *Innovation*   *Knowledge*   *Decision*   *Adoption*
                                            Awareness   *Implementation*
                                            Persuasion   *Confirmation*
                                            Convergence   *Consequences*
                                            Opinion leadership

DIFFUSION OF INNOVATIONS PROCESS

Figure 2: Conceptual Framework for the Design of Culturally Relevant AIDS Prevention Messages

Predisposing Factors

The "Predisposing Factors" domain of the theoretical framework contains components of 10 different existing health behavior models. The Extended Parallel Process Model (Witte, 1996) contains an Individual Differences component, while the predisposing factors of the Health Belief Model (Becker, 1974) include demographic variables and personal experience as cue to action. The Social Cognitive Theory (Bandura, 1994) classifies knowledge as a "personal factor," and the Stages of Change model (Prochasta & DiClemente, 1984) classifies knowledge about risk as "pre-contemplation." In the Transformation Model of Communication (Kreps, 1994), "health problem/risk" is categorized as an Antecedent Condition.

The Independent Communication Variables within the "Input" domain of the Input/Output Matrix (McGuire, 1989) include demographics, ability, personality, and lifestyle. The AIDS Risk Reduction Model (Catania, Kegeles, & Coates, 1990) posits that predisposing factors include transmission knowledge, labeling, risk assessment, and pre-existing aversive emotions. The Theory of Reasoned Action (Fishbein & Ajzen, 1975) asserts that predisposing factors include personality traits and demographics. Relevant demographics include age, sex, occupation, socioeconomic status, religion, and education.

In the Persuasive Health Messages Framework (Witte, 1995), Receiver Variables and Preferences, which constitute the "audience profile," include demographics (race, gender, socioeconomic status, literacy level, age, employment, primary language), psychographics, habits, customs, key values, preferences, and religious taboos.

According to Diffusion of Innovations theory (Rogers, 1995), "Prior Conditions" include previous practice, felt needs/problems, and innovativeness. In addition, the theory posits that the characteristics of the decision-making unit include socioeconomic characteristics and personality variables.

For the sake of clarity, and given that the theoretical framework of the present study was used primarily as an organizing framework, the various affective dimensions (both predisposing and following information exposure) are discussed within the Cognitive Processes section.

The model on the next page, Figure 3, highlights key components of the "predisposing factors" domain of the conceptual framework and introduces a review of literature about various individual factors that can influence AIDS preventive behavior.

Religiosity

The belief in a god or the supernatural, as well as belief in a related dogma, can have a profound impact on behavior (Zimbardo, Ebbesen, & Maslach, 1977). Religiosity has been shown to be a significant predictor of attitudes toward AIDS and toward people living with AIDS (Cowell, 1985; Rudolph, 1989). Individuals who perceive themselves to be active, traditionally conservative Christians tend to conclude that AIDS-related messages do not concern them, and they tend to agree with abstinence-based prevention messages without changing risky behaviors (Greene & Parrott, 1993).

Religiosity, which comprises dimensions of involvement and ideology, is a key concept in this study because it is believed that religiosity-related factors may serve as barriers to AIDS dialogue in the black church, as well as attitudinal constructs that can facilitate personal empowerment to practice AIDS preventive behaviors.

Predisposing Factors

Religiosity
Personality
Needs
Demographics: age,
  Gender, education, SES
AIDS risk factors
    Drug use
    Homosexual behaviors
    Teen sex
Cultural Factors in HIV
Transmission
    Truancy
    Homelessness
    Racism
    Sex-ratio imbalance
    Motherhood norm
AIDS prevention
  knowledge & experience

Cognitive Processes

Enabling Factors

MESSAGE DESIGN & DELIVERY

OUTCOMES

Environmental Factors

Normative Processes

Potential Barriers

CULTURAL CONTEXT

FIGURE 3: Predisposing Factors that Influence AIDS Preventive Outcomes

Allport and Ross (1967) assert that religiosity can operate as a "sincere and adaptive master motive in a believer's life," or it can grow from a self-centered orientation when a person engages in various religious activities as a means to other ends. The religious orientation scales developed by Allport and Ross posit four basic religious orientation types:

- The *social-extrinsic* individual considers church the place to form social relationships.

- The *personal-extrinsic* person tends to use religion for comfort, protection, relief, or social support.

- The *residual-extrinsic* believes some things are more important than religion.

- The *intrinsic* views religion as the orienting center of life and motivation, and sees private devotional activity as a genuine expression of religiosity because it is not practiced for ulterior motives.

Ellison and Gay (1990) identify three dimensions of religious commitment: affiliation (denominational preference), participation (attendance), and private religiosity. Private religious experience, such as frequent prayer or spiritual encounters, can convince people of their own uniqueness through their personal relationship with God, and it can foster self-esteem and a sense of personal efficacy. Prayer also can increase the sense of orderliness in a person's daily life (Antonovsky, 1987) and can promote hope. Zimbardo, Ebbesen, and Maslach (1977) observe that

> The personal consequences of faith and prayer are illustrated by the experience of pilgrims to Lourdes. . . . Although some physical healing does occur, most of the sick do not get cured. Nevertheless, as a result of the prayers and rituals, almost everyone experiences a psychological improvement and feels more hopeful and self-confident. (p. 36-37)

Batson and Ventis (1982) developed the Religious Life Inventory, which is based on a three-factor model: religion as means (to other ends: extrinsic), religion as end (in itself: intrinsic), and religion as quest (expression of open-minded religious search). The inventory categorizes religious sentiment as external, internal, and interactional; the external scale indicates the degree to which religion represents a means for gaining self-serving social approval, while the internal scale measures the degree to which religion is used to provide firm, clear answers to questions of certainty, strength, and direction. The

interactional scale represents the degree to which a person faces existential questions and contradictions open-mindedly.

Religiosity among African Americans

Recent surveys indicate that levels of church attendance and membership in church-related voluntary organizations are higher among blacks than whites (Roof & McKinney, 1987), that church involvement is more closely related to satisfaction in one's life for blacks than for whites (St. George & McNamara, 1984), and that blacks report higher levels of private religious involvement (Roof & McKinney, 1987).

In the National Survey of Black Americans, the first nationally representative sample of black adults in the U.S., more than 70 percent of 2,107 black adults said they belonged to a church, and 84 percent considered themselves to be religious. Further, 76 percent said religion was very important in their lives when they were growing up, and 77 percent indicated that they believe the church is still a very important influence in their lives (Billingsley, 1992).

Although recent evidence indicates that younger blacks are attracted to apostasy (Nelson, 1988), the younger blacks in the South have remained committed to the church (Taylor, 1988). In analyzing a national survey, Sherkat and Ellison (1991) found that younger blacks are less likely to be members of a neighborhood association. Trout (1989) conducted a survey of church-going and non-church-going black teens, in which she found that most youth were disenchanted with the church. Many youth who do not attend church said they felt the pastors of black churches were hypocritical and did not live up to their call as ministers.

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In a focus group study of television use among African-American teens, Moore and Waiters (1995) found that most of their religious opinions were related to parental authority and role models and views of religion itself ranged from self-centered to community-focused. Some questioned the necessity of church because their fathers did not attend or because they felt religion went beyond church. Those who were committed to church attendance often said that both male and female family members attended services with them. The teens agreed unanimously that going to church was not a measure of religiosity. While some criticized a minister's ability to interpret the word of God, none expressed criticism of the Bible as the word of God or of the concept of God itself.

Cannon (1988) comments that "in spite of every form of institutional constraint, racism, sexism, and classism, African Americans have been able to exist in another world, a spiritual world, a counterculture within the white-defined world, complete with our own sacred texts, spirituals, and religious practices" (p. 84). Cone (1986) argues that African Americans have taken on the task of creating "a new version of Christianity more consistent with its biblical origins" (p. 486). Murphy (1994) speculates that the black church, "with its direct experience of enslavement, exile, and ghettoization" may have constructed a spirituality "fully consistent with their biblical ancestors," a spirituality that is "a recovery of the spirituality of the Bible, lost through two thousand years of European interpretation" (p. 200).

Southern black religion tends to emphasize "otherworldliness," a simple theology of individual piety and a highly emotional worship style (Ellison & Gay, 1990). Murphy (1994) notes that many affirmations during worship services contain the phrase "I will,"

as in "I will pray," "I will rejoice and be glad," "I will go, to see what the end shall be." Murphy comments that this future tense shows that prayer, gladness, and blessings "can only be fulfilled in a world that has not yet arrived" (p. 175).

Many black churches emphasize religious role-taking with a "divine other," in which people define their own life circumstances in terms of a Biblical figure's situation, then interpret their situation according to what God would expect and want (Pollner, 1989). The movements of worship participants often repeat the actions of biblical figures, such as the gestures of Joshua's army surrounding Jericho or the children of Israel leaving Egypt (Levine, 1977). For those who hear the African-American preacher's sermon "in ordinary consciousness," it is typically a dramatization of biblical stories. But for those "in the spirit," the sermon shows those biblical stories "to be present in the church, in the bodies of the congregants, in the hard and real world of the United States . . . they reenact the Biblical dramas of deliverance, of passion and resurrection, and of freedom and fulfillment to come" (Murphy, 1994, p. 198).

A cornerstone of black theology is the belief in the inherent dignity and worth of each individual, grounded in the premise that God hates sin but not sinners. Smith (1985) comments that "for black people the church has been the one place where they have been able to experience unconditional positive regard" (p. 14). These churchgoers "are not only free from the restraints and indignities visited upon them by racist powers, but free to recognize themselves in the company of ancestors and saints" (Murphy, 1994, p. 200).

Religious involvement tends to cushion the harmful effects of adversity on black self-esteem. Murphy (1994) comments that most African Americans:

Know the religious insight that comes from their near-universal experience of racial exclusion and prejudice in the United States. The ceaseless attempts to limit and marginalize African Americans have challenged nearly every black individual to find ever-deeper personal resources of affirmation and compassion. African Americans have been challenged to become a new people, a "great nation" in the biblical phrase, and the struggle toward this destiny has given them a unique and profound understanding of God and his works. (p. 146)

The image of Africa "has been one of the primordial religious images of great significance" for African Americans (Long, 1986, p. 176), as shown by the strong orientation of the black church "toward the timeless places and events of the Promised Land" (Murphy, 1994, p. 171).

Fundamentalist churches tend to have stronger interpersonal networks, which provide spiritual and social support (Maton & Rappaport, 1984). The fellowship and networking within the black church can build feelings of self-esteem or personal empowerment. When a church member interacts regularly with other like-minded people, the interaction may reinforce role expectations and role identity (Ellison, 1993).

Perkins (1995) asserts that Christianity is the "inescapable point of reference marking African-American identity" (p. 161). In reflecting on her own upbringing, Perkins comments:

The rituals, music, and ethos associated with the Baptist religious practice of my youth provide a sense of connection not just to my own family, but even more profoundly, to the history of African Americans on this continent. I am deeply moved by the songs (the gospel chords and rhythms), by the joy of fellowship, and the warm embrace of the elders. (p. 161)

Murphy (1994) notes that the goal of the individual is to "develop an inner relationship with the spirit so that one's body and mind might show and share it with others at ceremonies" (p. 191). In many black congregations, each member plays a unique part in the worship experience – some people "move the spirit by sacred rhythms, swaying in place, singing, clapping, keeping time with the tambourines and sanctioned

instruments," while others move through the church, praying with their palms raised and "manifest the spirit through emptying their consciousness of their own personalities" (p. 158). The "ring shout" is a ceremonial form of worship with roots in the African diaspora and in the slave churches of the antebellum South. Participants gather to worship by forming a circle, calling songs, and moving counterclockwise while stamping their feet in rhythm.

African American churchgoers can gain affirmation that their personal conduct and emotions related to everyday events and experiences are reasonable and appropriate, and they can receive emotional support (Ellison, 1993). However, Perkins (1995) points out that

> To talk openly and critically (as distinct from negatively) about Christianity is to risk having to surrender one's membership card in the African American community. . . . Disclosure may be punished by ostracism or, even worse, by self-righteous proselytizing from those with whom we share our feelings" (p. 162-163).

Spirituality among African American Women

In a secondary analysis of data from the National Survey of Black Americans, Billingsley (1992) found that African American women are significantly more likely than black men to cite church as very important in their lives. About 86 percent of these women consider themselves religious (compared with 76 percent of men), 82 percent agreed that it is very important to send children to church (77 percent of men agreed), 80 percent consider church very important now (72 percent of men agreed), and 73 percent said they are members of a church (compared with 59 percent of men).

Further, 76 percent said they attend church at least monthly, compared with 61 percent of men; 84 percent pray daily (versus 68 percent of men); 71 percent watch

religious broadcasts weekly (compared with 63 percent of men); and 57 percent read religious books or other materials weekly, compared with 40 percent of men. In interpreting these patterns, Billingley speculates that most black men have a strong set of religious beliefs, but may not convert these into practice as frequently as black women do.

Williams (1995) asserts that African American women have a pervasive and influential voice in their families and communities, owing the power behind their voices to "our upright spiritual ancestors, to the lessons they taught us through their religious faith and practices, and to the sacred traditions they used to shape wholesome family life that modeled productive, positive action for the future, that inspired us to keep hope alive." (p. 189)

However, while women make up the majority in African American Protestant congregations, they are in the minority in positions of religious leadership (Lincoln & Mamiya, 1991). Goboldte (1995) argues that the African American church "tends to neglect the spirituality of African American women by legitimating the value of other cultures whose spiritual values may be based on power relationships" (p. 243). The nature of female leadership in African American churches may hinge on the extent that the surrounding community is cosmopolitan. In her ethnographic study of a racially mixed Catholic congregation in Philadelphia, Goboldte found that many African American women filled leadership positions beyond the sphere of conventional women's work to include positions as pastors, elders, and administrators.

Jordan (1991) has described a common attitude among many black women in which a woman is unwilling to "tell her business" to others outside her family because

she believes that handling things on her own is a moral imperative. But within the Christian circles of African American sisterhood, the dialogue may be quite different. Dona Marimba Richards, author of Let the Circle Be Unbroken, pointed out that "testifying," or speaking aloud about the day's or week's experiences within a circle of friends, is a spiritual anchor of African American culture:

> We would form a circle, each touching those next to us so to physically express our spiritual closeness... We shared the pain of those experiences and received from the group affirmations of our existences as suffering beings. As we "lay down our burdens," we became lighter. As we testified and listened to others testify, we began to understand ourselves as communal beings, no longer the "individuals" that the slave system tried to make us. . . . We became, again, a community. (quoted in Wade-Gayles, 1995, p. 96)

Bettye Parker-Smith, an African-American writer who grew up in Mississippi, reflected that a group of women gathered in her mother's parlor once a week or whenever a sister was in need of prayer.

> I was fascinated by the shifting motion in the women's shoulders, the lifting and butterfly opening and closing of their hands, and the sporadic shaking of their heads. I knew from these movements and from the songs they sang that they were praying and testifying... When I became an adult and understood the meaning of sisterhood, I realized that the women became stronger individually and collectively as a result of their spiritual bonding, and the children were the beneficiaries of their strength. (quoted in Wade-Gayles, 1995, p. 97)

The spiritual bonds among religious African American women collectively could empower them to provide social support and to look out for one another in an effort to avoid the tragic consequences of HIV infection. Religiosity, however, is a complex factor that includes some beliefs that can enable AIDS preventive behavior while other beliefs can serve as barriers to prevention. While an individual's religiosity may influence his or her decisions about sexuality in many ways, the same person may have other risk factors as well. The following section describes several of the risk factors that

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public health practitioners traditionally have considered in planning HIV prevention initiatives.

Personality Traits

Personality factors categorize individuals in terms of how different people display attitudes and actions toward the same object (Cacioppo & Petty, 1982). Some scholars have identified the personality characteristic of sensation seeking as a fundamental antecedent to attitudes and behaviors related to sexuality (Sheer & Cline, 1994). A sensation-seeking predisposition is the only personality characteristic that has been shown to strongly influence sexual behavior (Lasorsa & Shoemaker, 1988; Weinstein, 1989).

According to the Theory of Reasoned Action (Fishbein & Ajzen, 1975), personality traits that can influence individual decision-making include introversion-extroversion, neuroticism, authoritarianism, and dominance. Maddi (1984) identified eight major personality constructs: locus of control (internal vs. external), need for achievement, need for power, self-disclosure, Machiavellianism, androgyny, sensation seeking, and cognitive complexity. The Structural Analysis of Social Behavior (SASB) model, a behavioral classification system developed by Benjamin (1979) and others, is represented by a series of quadrants that provide oppositional constructs describing the "interpersonal other," "interpersonal self," and the "intrapsychic other to self." A few constructs that likely would predict compliance or non-compliance with AIDS prevention advice include self-protection/self-enhancement, self-oppression, self-monitoring/self-restraining, spontaneity, self-neglect, assertiveness/self-identity, and deferring/submitting. Statements about how individuals relate to others or how they view

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themselves accompany each model construct. For example, for self-protection/self-enhancement, the statements include:

- Subject (S) comfortably looks after his or her own interests and protects him/herself.
- Because S wants to help him/herself, S tries to figure out what is really going on within him/herself.
- S practices and works on developing worthwhile skills, ways of being.

One statement for the self-oppressing construct is "S makes him/herself do and be things which are known to be not right for S. S fools him/herself." For self-neglect, a statement is "S is reckless. S carelessly lets him/herself end up in self-destructive situations." For spontaneity, typical statements include: "S lets him/herself drift with the moment. S has no internal direction, goals, or standards" and "S freely, easily, and confidently lets him/herself do whatever comes naturally." For the self-monitoring/self-restraining concept, typical statements include: "S very carefully watches, holds back, and restrains him/herself" and "S tries very hard to make him or herself be like an ideal."

In relation to others, an assertive person "speaks up, clearly and firmly states his/her own separate position" and "has a clear sense of who he/she is" separately from another person. A deferring/submitting person, by contrast, "feels, thinks, does, becomes what he/she things Other wants" and "gives up, helplessly does things Other's way without feelings or views of his/her own." (Benjamin, 1984, p. 131-133)

A tendency toward depression has been shown to be a barrier to self-efficacy in practicing AIDS preventive behaviors (Leigh, 1995). African Americans living below the poverty level have the highest rate of depression for any group (Liu & Yu, 1985). The

intention to commit suicide is considered a predictor of risky behavior, including sexual behavior and drug use.

Needs

Maslow's (1968) motivation theory defines various behavioral motives in terms of a hierarchy of basic physiological drives and psychological needs. At the bottom of the hierarchy are physiological needs, such as hunger and thirst, and the higher-order needs are safety (security and protection), social (sense of belonging), esteem (self-esteem, recognition, and status), and finally self-actualization needs (self-development and realization).

Among impoverished minorities, concerns about level one needs -- the adequacy of food, shelter and physical safety -- tend to supersede any concerns about preventive health measures (Nyamathi, 1992). Sheer and Cline (1994) identified three types of motives likely to predict sexual behavior among college students: reduction of health risks, related to the need for safety and security; pleasure seeking, a physiological need; and maintaining a good physical or psychological relationship, related to affiliation needs.

Demographics

A defensible attempt to theorize about the predictors of HIV infection among African Americans, or any population for that matter, requires both synthesis and deconstruction of both complex and contradictory information. In part, this is because the black community is not a monolithic entity nor is human behavior ever effectively or fully explained by a simple model or categorization scheme. Treichler (1988) argues that a more holistic approach includes an analysis of "the intersections of gender, race, and

class in relation to an illness profiled in terms of nonintersecting categories" (p. 232). In examining the factors that can predispose an individual to attend to an AIDS prevention message, the following section about demographic variables includes discussion about age, gender, education, and socioeconomic status.

Age

AIDS is the number one killer of all American adults aged 25 to 44. Given that the latency period between initial HIV infection and the appearance of the clinical symptoms of AIDS can be 10 years or longer, most diagnosed individuals in the 25-44 age group probably became infected when they were in the 15 to 34 age range. About 17 percent of the nation's 34 million African Americans are between 15 and 24, and 32 percent are between 25 and 44 (U.S. Bureau of the Census, 1997). The potentially virulent spread of HIV among minority youth is attributable to the significant correlation of HIV infection with sexually transmitted diseases (USCM, 1990).

Reliance on AIDS case surveillance data has severely underestimated the seriousness of the health threat to adolescents. AIDS incidence has increased much more rapidly in recent years among younger individuals born in 1960 or later than among older individuals (Rosenberg, 1995), and especially among African American adolescents (DiClemente, 1993).

In some minority communities, sexual activity begins as young as age 11 or 12 for girls and a few years older for boys. Considering that African American teens tend to initiate sexual involvement earlier than white teens, AIDS messages are likely to be most effective if they target African American youth before age 12 (St. Lawrence, 1993).

Gender

In 1986, the U.S. Centers for Disease Control reclassified a significant number of "unexplained" AIDS cases as having been heterosexually transmitted to and from women (CDC, 1986). Shortly thereafter, public health officials noted that African Americans were the only group in which male and female teens were afflicted with AIDS in approximately the same numbers (National Research Council, 1988).

Treichler (1988) asserts that most dialogue about female HIV risks has given women "the false belief that they were invulnerable" and often focused on "advising 'us' (women) to protect ourselves from 'them' (men)" (p. 197). In addition, the scientific community often has defined the risk "status" of women in terms of their sexual partners rather than in light of their own unsafe behaviors (p. 215).

Not only has AIDS affected African Americans disproportionately in comparison with other ethnic groups, but also public health officials have noted significant gender differences in AIDS rates within the black community.

Although black women account for 13 percent of all women (U.S. Bureau of the Census, 1997), they account for nearly 60 percent of all AIDS cases among women. Black males are nearly five times more likely than white males to get AIDS (CDC, 1996). There are seven times more white males than black males, and black males account for 12 percent of the U.S. male population (U.S. Bureau of the Census, 1997).

Age-based patterns of AIDS rates among African American females and males, as compared with proportions of African Americans in the U.S. population, are shown in Figures 4 and 5 on the following page.
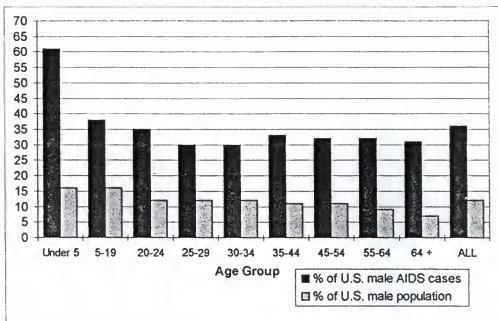
FIGURE 4: AIDS Cases among Black Males, Cumulative through June 1997
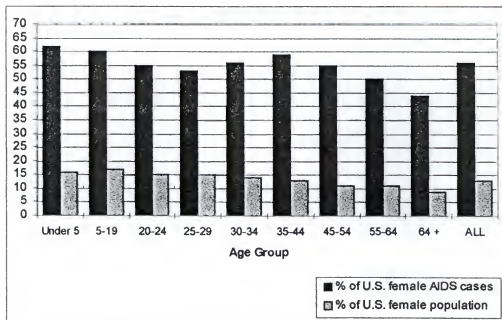
FIGURE 5: AIDS Cases among African American Females, Cumulative through June 1997

African American women are 15 times more likely to be HIV infected than are white non-Hispanic women, and black males are five times more likely to be infected than are white males (CDC, 1996). Among African Americans aged 25 to 44, AIDS accounts for 1 in every 3 deaths among men and 1 in 5 deaths in women (CDC, 1996). Among African Americans in their thirties, an estimated 1 in 33 black men and 1 in 100 black women were living with HIV infection as of January 1993. Among all American adults aged 18 to 59, the estimated HIV infection rate was 1 in 213. The estimated incidence of HIV infection has been lowest among white women and has declined markedly during the 1990s among white males, especially those older than 30 years. However, HIV incidence has continued to rise among women and minorities, particularly among black women (Rosenberg, 1995).

Adult women account for an increasing number and percentage of AIDS cases nationwide (Ellerbrock, Bush, Chamberland, & Oxtoby, 1991). In 1987, AIDS was 13 times more common among black women than among white women (Selik, Castro, & Pappaioanou, 1988). Among black females older than 12, 48 percent of the AIDS cases reported between 1981 and June 1996 were infected through injecting drug use, 16 percent through heterosexual contact with an injecting drug user, 16 percent through other heterosexual contact, and 2 percent through sex with a bisexual male.

Among black males older than 12, 39 percent of all AIDS cases between 1981 and June 1996 were infected through homosexual contact, while 36 percent were infected through injecting drug use, 8 percent through homosexual contact and injecting drug use, and 6 percent through heterosexual contact.

Education

Lower levels of education among African Americans have contributed to the higher prevalence of AIDS transmission in the black community (LaSalle, 1990). While the average schooling for white Americans is 12.8 years, the average schooling for African Americans is 11.6 years (Kirsch, Jungeblut, Jenkins, & Kolstad, 1993). African American women are generally better educated than African American men at all levels except the doctoral level (Lassiter, 1995).

Levin (1987) argues that the most powerful determinant of health is socioeconomic status and that by eliminating poverty and low literacy, the greatest amount of health enhancement could be accomplished. Low literacy is a considered a significant barrier to effective HIV prevention education among African Americans (Rotheram-Borus, Koopman, Haignere, & Davies, 1991; Mays, 1989).

The National Center for Education Statistics groups people into five levels of English literacy according to their ability to complete prose, document, and quantitative tasks. About 47 percent of Americans 16 or older demonstrate literacy skills in the bottom two levels. Of the 20 percent classified in the lowest literacy level – those who can complete only tasks involving brief, uncomplicated texts – nearly two-thirds never complete high school. Whites score significantly higher than any of the other nine racial-ethnic groups (Kirsch, Jungeblut, Jenkins, & Kolstad, 1993).

Socioeconomic Status

Poverty and deprivation among African Americans are clearly related to death from AIDS and other diseases, as well as high rates of infant mortality (Gleaton & Johnson, 1995). The increase of HIV infection in the black community has been

attributed to economic factors, particularly joblessness (Briggs, 1987) and poverty

(LaSalle, 1990). However, Males (1996) offers a contradictory argument, asserting that

> When the surplus or deficit of HIV acquisition for each age and ethnic group is standardized according to each group's surplus or deficit of poverty, the discrepancy between young and old age groups disappears for both sexes. (p. 1480)

> The higher HIV infection rate among black men is not explained by poverty.

When controlling for economic disadvantage, however, the disproportionate rate among

black women remains. Males argues that this indicates that

> Poverty places women at a higher net risk, perhaps rendering them vulnerable at young ages to sexual violence, prostitution, and sexual contact with older men. . . Critical issues in AIDS prevention are not demographic or behavioral, but relate to reversing the United States' consignment of a uniquely high and rising proportion of its youth and nonwhites to poverty. (p. 1480)

> While race and ethnicity are not *causally* associated with increased HIV risk,

Rosenberg (1996) classifies these factors as "markers for social factors such as low

socioeconomic status that are the root causes of the high prevalence rates seen in

minorities." Further, income-specific categories of AIDS rates cannot be derived from

national AIDS surveillance because such data is not collected. "Even if it were,"

Rosenberg argues, "inadequacies in available measures of SES and other social factors

might preclude a complete explanation of the large excess of AIDS cases among

minorities." (p. 1480)

The determinants of teen pregnancy (Frost & Forrest, 1995) and lack of condom

use (Roper, 1993) among African American youths are deeply intertwined with poverty

and disadvantage. In addition, a constant personal concern about poverty can

overshadow perceptions of AIDS risk. For example, in an interview study of sexually

active female minority teens (90 percent of whom were black), Overby and Kegeles (1994) found that although most girls were concerned about AIDS, their worries about poverty-related issues were often greater.

Patterns of poverty tend to be age-related. Within each racial category, 21 percent of individuals aged 15 to 24 are impoverished, which is twice the rate of poverty among those aged 25 to 59 (U.S. Bureau of the Census, 1993). Nearly 15 percent of all U.S. residents live below the federal poverty level, defined in 1990 as $13,254 of cash income for a family of four, and 31 percent of these people are African American (U.S. Bureau of the Census, 1997). Poverty affects 32 percent of all black Americans and 36 percent of all black women. About 48 percent of all black female-headed families have incomes below the poverty level, while 75 percent of the 2 million black families in poverty are maintained by women with no husbands present (U.S. Bureau of the Census, 1990).

African Americans living below the poverty level have little or no access to preventive medical care (Leigh, 1995). Poverty often contributes to poor health because people with low incomes typically have less access to medical care, cannot pay for needed services and medication, and tend to delay seeking care until the condition becomes life-threatening. Poverty also can contribute to crowding living conditions, which can lead to increased exposure to HIV (Florida Health Net, 1997).

Among African Americans living with AIDS, poverty can predict lower survival times. The mean survival time among blacks diagnosed with AIDS is six months, as compared with 18 to 24 months for whites. For many whites with a higher level of education, a lost job can contribute to a sense of outrage about the disease and motivate them to fight for what is being lost. But African Americans who do not have these

advantages may lack this sense of loss. Without the desire to fight AIDS, they may delay in seeking medical care (Friedman, Sotheran, & Abdul-Quader, 1987). Whether a person has AIDS or not, socioeconomic status has been shown to affect one's self-concept and to determine one's sense of powerlessness (Dodson, 1981).

AIDS Risk Factors

According to the AIDS Discrimination Unit of New York City Commission of Human Rights, "it is behavior and not one's race or ethnicity that is the operative risk factor" for HIV infection (quoted in Gleaton & Johnson, 1995, p. 45). The following discussion highlights several behaviors and predisposing conditions that can place African Americans at a greater risk of HIV infection: homosexual behaviors, teen sex, truancy, homelessness, racism, sex-ratio imbalance, motherhood norm, and drug use.

Homosexual Behaviors

For many African Americans, the stigma of an HIV-infected family member with a history of drug abuse is not nearly as great as the stigma of explaining that a family member was diagnosed with AIDS as a result of homosexual conduct (Gleaton & Johnson, 1995).

Homosexuality is believed to exist in the black community to the same extent that it exists among other racial groups. Across all racial groups, 13 percent of men and 7 percent of women are exclusively gay or lesbian throughout their lives, and 37 percent of all men report having had at least one homosexual experience. While no significant studies have assessed the incidence patterns of homosexuality among blacks, it has been determined that many black men and women reject the labels used to describe sexual minorities but continue to be sexually active with persons of the same gender. Further,

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AIDS outreach workers have found that many black women who identify themselves as lesbians engage in prostitution and injecting drugs (Gleaton & Johnson, 1995).

Heterosexual African American women may be more vulnerable than white women to sexually transmitted HIV infection because a larger proportion of black gay men than white homosexual men report having sex with both men and women – 30 percent for black gay men, compared with 13 percent for white gay men (Friedman, 1989). On the other hand, the Multicenter AIDS Cohort Study found that black homosexual men had the lowest risk profile for receptive anal intercourse, use of anonymous sexual partners, and recreational drug use when compared with white and Hispanic homosexual men. Both black and Hispanic gay men more frequently reported a history of sexually transmitted diseases (STDs) than whites (Easterbrook, 1993).

Teen Sex

The sex drive of a typical 15- or 16-year-old is about as strong as it will be over the course of a lifetime (Walster & Walster, 1980). National data provided by the Alan Guttmacher Institute (1994) show that 9 percent of 12-year-olds and 16 percent of 13-year-olds have had sexual intercourse, and that throughout the 1980s the proportion of teens engaging in sex rose while the age at which they first did so decreased.

Most school-based HIV prevention programs are taught at higher grade levels (Forrest & Silverman, 1989), neglecting younger teens in middle school and junior high who also have a high prevalence of sexual behaviors that put them at risk for HIV infection (DiClemente, Durbin, Siegel, Krasnovsky, Lazarus, & Comancho, 1992; Durbin, DiClemente, Siegel, Krasnovsky, Lazarus, & Comancho, 1993; Brown, DiClemente, & Beausoleil, 1992).

Podschun (1993) contends that the role of sex in these the lives of young African American teens is neither an erotic expression nor a response to romantic love, but rather a part of the "warm body syndrome" or the search for comfort. Many cannot practice safer sex because it is beyond their means to insist on cooperation from their partners.

African American teens commonly have one main partner but also engage in sexual relations with other casual partners (Bowen & Michal-Johnson, 1990). According to one survey, 80 percent of teen mothers did not consciously want to get pregnant but did so anyway because of a lack of knowledge about contraception or a desire to be liked by a particular boy. When they do get pregnant, poor teenagers are less likely to get an abortion because having a baby carries the possibility of love and purpose (National Research Council, 1988). Because of inadequate contraceptive usage, African American women are twice as likely as white women to experience an unplanned pregnancy (Lassiter, 1995).

A household survey of black and Hispanic youth (Ford & Norris, 1993) showed that young black men reported the earliest initiation of sexual activity and the most partners. In a survey of urban minority high school students (Walter, 1993), 67 percent reported having had sexual intercourse. More than half reported having intercourse during the past year, and of these students, 33 percent had multiple intercourse partners, and 10 percent reported that they previously had been diagnosed with a STD. Age, ethnicity, and contextual factors such as academic failure, substance use, adverse life circumstances, and lack of cues to prevention were strongly associated with AIDS-risk behaviors, while cognitive factors such as knowledge and beliefs about AIDS had little explanatory power.

In an interview study of sexually active female minority teens, 90 percent of whom were black, Overby and Kegeles (1994) found that 41 percent of these subjects reported knowing someone with AIDS. The median number of sex partners was three, 55 percent had had a STD in the past, and 77 percent had been pregnant. However, most perceived themselves to be at low personal risk because of a current monogamous relationship, lack of intravenous drug use, and an implicit trust in their partner's safety from HIV infection.

Cultural Factors in HIV Transmission

Truancy: Many school dropouts who are at risk for HIV infection because they are hard to reach with prevention information, and because they tend to be distrustful of adults, they often have lower self-esteem, and are educationally and emotionally impaired (Rotheram-Borus, Koopman, Haignere, & Davies, 1991).

One cause of truancy and risky behaviors among African American boys is their socialized expectation that men must demonstrate their masculinity in the streets, not at home (Cazenave, 1992). Schultz (1969) commented that African American boys strive to achieve a 'rep' on the street because they perceive that they do not have much status anywhere else. This "rep" is often earned through sexual conquests, toughness, expressive styles in speech, dress, and personal appearance, liquor consumption, and the ability to command respect (Hannerz, 1969).

Homelessness: Crowded living conditions in ghettos and homeless shelters can expose large numbers of people to HIV transmission and AIDS-related illnesses such as tuberculosis (Florida Health Net, 1997). The HIV infection rate among the 1.5 million

homeless teens in the U.S. is 2 to 20 times higher than all other adolescent groups (Rotheram-Borus, Koopman, Haignere, & Davies, 1991).

Runaways are at risk of HIV infection primarily through sexual activity rather than injecting drug use (Stricof, Kennedy, & Nattell, 1991).

The low level of literacy among most homeless people is a significant barrier to effective HIV prevention education. In addition, HIV prevention messages are often lost on them to more immediate crises. Any AIDS prevention program that does not help them meet basic necessities such as food and shelter is unlikely to succeed (Sondheimer, 1992). Although many runaways are well aware of the dangers of AIDS, these teens are more concerned about day-to-day survival than death in five to 10 years from AIDS (Rotheram-Borus, Koopman, Haignere, & Davies, 1991).

In the United States, the 1996 point-in-time estimate of the number of homeless people is 760,000 (National Law Center on Homelessness and Poverty, 1996), and an estimated 7 million – nearly 3 percent of the total population – report they have been homeless at some point in their lives (HUD, 1994).

Racism: In a survey by Herek and Glunt (1993), 51 percent of black respondents said they believe that the AIDS epidemic is being used to promote hatred of minority groups. Memmi (1968) defines racism as an ideology which assigns character traits to oppressed individuals as an expression of their situation and which promotes passivity among them.

A barrier to AIDS prevention among African Americans, both real and perceived, is the racial discrimination they often encounter when seeking information or other help (Leigh, 1995). Exposure to racism can erode an individual's sense of self worth and self-efficacy. Langner (1965) argues that low social status "inhibits the development or maintenance of

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ego-strength," which involves "adaptive ability, planning for individual survival, conscious control over self, and conscious attempts to control the environment" (p. 366). Lassiter (1995) found that individuals

> Vary in their perception and internalization of stressful racial situations, with the perception and appraisal of a stressful event determined by the person's intelligence, education, self-esteem, previous experiences, and coping style. (p. 2)

Lack of self-esteem in turn has contributed to the spread of HIV and to unwanted teenage pregnancies (Florida Department of Health, 1997). Among African American mothers, a higher perception of racism has been found to be a predictor of low birth weight and pre-term delivery (Green, 1995).

Sex-Ratio Imbalance: The scarcity of eligible men polarizes the status of being single versus not single and puts pressure on some black women to give in to unsafe sex to maintain a relationship. An African American woman in a relationship with a male partner often has the prestige of being "kept" (Mays & Cochran, 1988).

The lack of single black men is exacerbated by the fact that 23 percent of all black males are incarcerated or under the supervision of the corrections system (Maurer, 1990). Of American black men aged 16, only one in four can expect to reach the age of 25 without being involved in drugs, in prison, or dead (Sepulveda, Fineberg, & Mann, 1992).

The sex-ratio imbalance, the percentage of single adult men compared to the percentage of single adult women, is more prominent for black women than for white women (Mays & Cochran, 1988). Nationally, the ratio of single college-educated black women to similar men is two to one (Staples, 1981). Changes in the sex ratio for various age groups, based on national population data (U.S. Bureau of the Census, 1997) are shown in Figure 6.
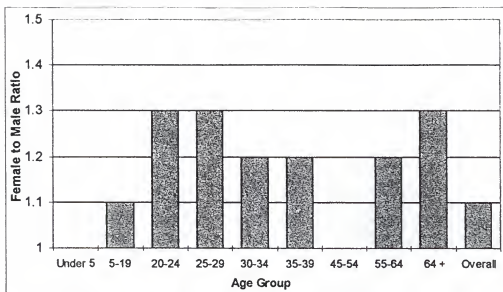
FIGURE 6: Sex-Ratio Imbalance among African Americans

Motherhood Norm: When an African American woman seeks the opportunity to become a parent, her attempts to conceive can put her and her baby at risk of contracting AIDS. Historically, motherhood has been a more valued and meaningful role for the black woman than the role of wife (Bell, 1971). The motherhood norm in the black community also is rooted in a fear of racial genocide because children represent potential cultural survival (Tobin, Clifford, Mustian, & Davis, 1975). This racial genocide belief is the perception that those in authority are systematically trying to eliminate African Americans from society by limiting their opportunities for child bearing, through welfare-based economic sanctions, condom distribution, imprisonment, and other actions perceived to be part of a government conspiracy.

Some African American women choose motherhood out of a sense of powerlessness (Bauman & Udry, 1972), including restricted opportunities to have a

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professional career (Nsiah-Jefferson, 1989). The birth of a child may also serve as a social bond to a continuing relationship with a black male, who is considered a precious commodity because of the scarcity of men (Mays & Cochran, 1988). Many black teens who perceive little or no opportunity to improve their status in life may desire a child as something tangible and significant for which they themselves will be responsible (Florida Health Net, 1997).

Drug Use: More than half of all AIDS cases among African Americans are the result of intravenous drug use (LaSalle, 1990). Injecting drug use or contact with a user has been a risk factor in 65 percent of all AIDS cases among black females. Three-quarters of black males who were infected through heterosexual contact contracted AIDS through sex with an injecting drug user. Injecting drug use or contact with a user has been a risk factor in 47 percent of all AIDS cases among black males, compared with 17 percent among white males (CDC, 1996).

Substance use can contribute to risky sexual behaviors because it reduces inhibitions, impairs judgment, and increases the incidence of unprotected sex. In the U.S., 15 percent of women of childbearing age have problems with alcohol and other drugs, and 11 percent of pregnant women use at least one of the following drugs: cocaine, heroin, amphetamines, methadone, PCP, or marijuana.

One third of African-American women report using illicit drugs at some point in their lives, while 7 percent report current use of an illicit drug (Horton, 1992). Nyamathi (1993) reported that non-intravenous drug use and high-risk sexual activity is more prevalent among black women than Latina women. Crack cocaine is a sexual stimulant, and its use often leads to high-risk sexual activities (Fullilove, Fullilove, & Bowser,

1990). Within a drug culture, prostitution is often performed either for money to buy narcotics or for the drugs themselves (Stone, 1989).

Kim (1993) found that injecting drug use is significantly associated with sexual risk-taking, and women are more likely than men to have an intravenous drug-using sexual partner. Female intravenous drug users usually have few resources and also must care for children (Wofsy, 1987). If she has a sexual partner, most likely he too is an intravenous drug user (Cohen, Hauer, & Wofsy, 1989) who may fail to provide financial support, and may inflict sexual or physical abuse (Chaffee, 1989). Many female injecting drug users have increased stress and low self-esteem because of the stigmatization that results from the drug use or from the prostitution they must practice to support their habit user (Cohen, Hauer, & Wofsy, 1989).

Intravenous drug use is high on the hierarchy of AIDS risk factors because needles allow direct exchange of blood from one person's body into the bloodstream of another. In addition to syringes used for intravenous drug use, needles used for tattooing, blood transfusions, insulin injections, vaccinations, acupuncture, and body piercing also can expose a person to HIV if they are not properly cleaned (Gleaton & Johnson, 1995).

AIDS Prevention Knowledge and Experience: AIDS is but one of many crises facing black communities, including other sexually transmitted diseases, substance abuse, unemployment, black-on-black crime, discrimination, unwed pregnancies, and lack of opportunities for educational advancement (Smith, 1995). Despite massive public education campaigns, many people remain confused about how HIV is transmitted. The existence of higher misperceptions about AIDS among African

Americans supports the conclusion that existing messages targeted at general populations have not affected most African Americans who are at risk of HIV infection.

People living with AIDS generally are portrayed in the media as either white gay men or street people abandoned by family and friends (Schiller, Crystal, & Lewellen, 1994). This construction of HIV has led to distancing and denial of personal risk by people who don't relate to these "social deviants." For example, African Americans and Latinos are more likely than whites to report that "all gay men have AIDS" (DiClemente, Boyer, & Morales, 1988). Many black men believe they are not at risk for getting HIV as long as they do not engage in sex with a white gay male (Peterson & Marin, 1988). In addition to misperceptions caused by media distortion, low knowledge about AIDS has been linked to religiosity and conservative political convictions (Peruga & Celentano, 1993).

Rotheram-Borus, Koopman, Haignere, & Davies (1991) found that male runaways and juvenile delinquents misperceived that blood donation was riskier than blood transfusion, and delinquents were more likely to believe that sex without a condom with someone who does not look sick is safe. Male delinquent runaways were significantly less knowledgeable about AIDS than non-delinquent runaways.

AIDS Prevention Negotiation with a Partner: In an interview study of predominantly black, sexually active female teens, Overby and Kegeles (1994) found that 65 percent had never discussed actual risk or past behaviors with their partners, and 67 percent said their partner would feel hurt, insulted, angry, or suspicious if he were asked about his AIDS risk factors. Because the black community often encourages women to be subordinate to men, women often are emotionally and economically dependent upon

their men and may not be in a position to negotiate AIDS preventive behaviors such as insisting that a sexual partner wear a condom (Worth, 1990).

Prior Condom Use: DiClemente (1992) found that minority junior high students who had a history of three or more sex partners were half as likely to use condoms consistently. Among sexually active female minority teens, 90 percent of whom were black, 98 percent were aware that condoms may prevent AIDS transmission, 64 percent used condoms half the time or less when they had sex, and most who did use condoms reported that they used them primarily for contraception (Overby & Kegeles, 1994).

The AIDS in Multi-Ethnic Neighborhoods Study (Catania, Coates, Kegeles, Fullilove, Peterson, Marin, Siegel, & Hulley, 1992) showed that only 9 percent of minority heterosexual males reported always using condoms, while 48 percent of gay/bisexual men reported always using condoms. Sexual communication and the sexual enjoyment value of condoms were correlates of condom use among all subjects.

Wilson, Kastrinakis, D'Angelo and Getson (1994) found that urban black adolescent males were more likely to use condoms if they had reached a higher grade level in school, if they had had two or more sexual partners in the past six months, if they had initiated communication about contraception with their sexual partner(s), if they had a desire for STD prevention when using contraceptives, and if they had received a parental suggestion to use condoms. Black male teens were less likely to use condoms if they had lower levels of knowledge about condom use, if they had a history of impregnating a partner or of having contracted a STD, or if their partner was dissatisfied with condoms. Neither the desire for pregnancy prevention nor the suggestions by friends to use condoms were predictors of condom use. Among urban minority high

school students who reported having sex in the past year, 75 percent had never or had inconsistently used condoms (Walter, 1993).

Environmental Factors

In Bandura's (1994) Social Cognitive Theory, "Environmental Factors" are divided into three domains: physical, institutional, and social. The Persuasive Health Messages Framework (Witte, 1995) classifies the environment as a "transient" factor, and environmental variables include residence and cultural values. The Transformation Model of Communication (Kreps, 1994) includes "quality of life" as an environmental factor. Diffusion of Innovations theory (Rogers, 1995) asserts that the norms of a social system set the stage for the spread of a new idea within a particular social network. In Gerbner's (1956) General Model of Communication, he alluded to environmental factors in the physical and social setting part of his model, which states: "Someone—perceives an event—and reacts—*in a situation*."

The model shown on the following page, Figure 7, highlights key components of the "environmental factors" domain of the conceptual framework and introduces a review of literature about these factors and their relevance in designing AIDS prevention messages. While normative processes are described in a later section of the literature review, the "environmental factors" section will describe several specific types of norms that characterize and influence the social environment within which an individual makes protective or risky behavioral decisions.
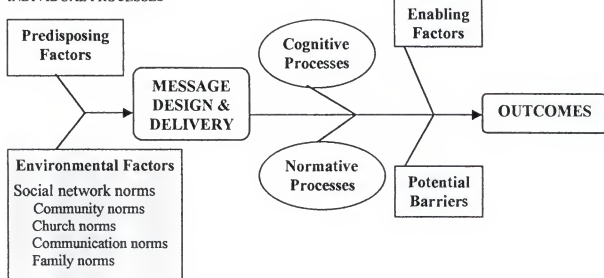
FIGURE 7: The Role of Environmental Factors in AIDS Prevention

Social network norms

African-American community norms

The black community is not just a geographic grouping or ethnic affiliation of

isolated individuals and families, as presented by many sociological studies. Blackwell

(1985) defines it as a social system, commenting that:

> Within the community, value consensus and congruence exists; a significant
> segment of its constituents share norms, sentiments, and expectations... Even
> though diversity exists within the community, its members are held together by
> adherence to commonly shared values and goals. (p. 14)

Blackwell argues that the black community also is held together by white

oppression and racism, but Billingsley (1992) challenges that view, asserting that black

religion "exists parallel with but not subservient to white religion" (p. 71). Community-level advocacy does appear to be a uniting factor, as shown by the National Survey of Black Americans (1980), in which 90 percent of African Americans agreed with the statement that blacks "should work together as a group," 89 percent agreed that "black women should work together," 87 percent agreed that blacks "should work through the present system through political participation," and 74 percent agreed that "black women should fight for both blacks and women."

Geographically, most black families live in neighborhoods where most of their neighbors are also black. In 1989, a national survey showed that 80 percent of African Americans lived in predominantly black neighborhoods (Billingsley, 1992). Parsons (1960) asserts that the geographic dimension of any community is not limited to the set of physical boundaries along its periphery because it can include places where people go to belong to a group. These can include places of entertainment, sources of employment, stores, churches, friends, relatives, streets, and roads.

The term "community" permeates the discourse of health planners, frequently appearing in their talk, mission statements, books, and reports about the future of public health. Despite the prominence of the term, it is extremely rare to find a public health document offering a definition or explanation of community (Wieder & Hartsell, 1996).

Effrat (1974) defines community in terms of the institutions that serve its residents' needs, such as hospitals, churches, family, government, and other organizations. Billingsley (1992) states that the black community is largely defined by four sets of organizations – the church, school, business enterprise, and the voluntary organization – "which grow out of the African-American heritage, identify with it, and

serve primarily African-American people and families" and which serve to "anchor the community and can be galvanized into collective action when circumstances or leadership commands" (p. 73).

Although many sociologists argue that the black community is not organized, Billingsley contends that "there is an organization, agency, or institution for every conceivable function in the black community today. They are, however, sometimes small and uncoordinated, and uncooperative with others. And they sometimes spring up and dissolve too soon to complete their missions" (p. 73).

Billingsley (1992) identified 12 key systems through which American society influences black families: economic, political, health, housing, educational, welfare, criminal justice, military, transportation, recreation, communications, and religious systems. He classified these systems into four major sectors: government, private business, voluntary nonsectarian, and religious.

Follett (1919) defines community in terms of its processes of interaction, socialization, shared interests, or common endeavors. Goode (1957) proposed eight characteristics of a community: shared values among its members, role definitions shared by both members and non-members, a common language applied to communal action but only partially understood by outsiders, power over its members, social limits that are reasonably clear, a sense of identity binding its members, continual maintenance of its membership, and production of the next generation through a socialization process.

In a statement to the Congressional Black Caucus, Franklin and Norton (1987) noted that "persistent poverty has eroded but not destroyed the strong, deep value framework that for so long has sustained black people" (p. 4). African Americans cope

by banding together to form a network of intimate mutual aid and social interaction with neighbors and kin (Billingsley, 1992). The black community "has always been an agent for its own advancement," and "the self-help tradition is so embedded in the black heritage as to be virtually synonymous with it" (Franklin & Norton, 1987, p. 4).

In a 1989 statement issued by the Joint Center for Political and Economic Studies, Franklin and Norton asserted that African Americans

> Have always embraced the central values of the society, augmented those values in response to the unique experiences of slavery and subordination, incorporated them into a strong religious tradition, and espoused them fervently and persistently. These values – among them, the primacy of family, the importance of education, and the necessity for individual enterprise and hard work – have been fundamental to black survival. These community values have been matched by a strong set of civic values, ironic in the face of racial discrimination – espousal of the rights and responsibilities of freedom, commitment to country, and adherence to the democratic creed. (p. 3-4)

Many sociologists have defined community attachment or ties in terms of involvement, satisfaction, and community orientation. Attachment measures are typically based on social interaction, such as how well residents feel they fit into the community. Billingsley (1992) notes that most black people, wherever they live, identify with their heritage to a considerable degree; even those who seldom visit black neighborhoods have a potentially powerful connection with black causes and issues.

Goudy (1977) found that people are most satisfied with their community when they have strong primary relationships, when they participate and take pride in the community, and when there is shared decision-making. Community involvement has been measured in terms of connection, manipulation, and attendance (Stamm & Fortini-Campbell, 1983), orientation to local facilities, knowing neighbors' names, frequency of neighborly visits (Finnegan & Viswanath, 1988), membership in formal organizations

(Litwak, 1960), existence of a personal social network, and how people form friendships (Omari, 1956). Janowitz (1952) found that socioeconomic status is positively related to community involvement.

Church norms

From a systems perspective, the black churches can serve as miniature, dynamic communities that present an opportunity for developing and implementing health promotion programs (Castro, 1995). The black church has a long and distinguished tradition of leading and caring for its people in times of great suffering, and it often has served as the impetus for education and change in times of crisis through pastoral activism and church mobilization.

When the black slaves came to America, "the new tribe, of which God was the center, was the black church" (Evans, 1995, p. 75). Their hymns and spirituals communicated ideas about salvation, freedom, judgment, punishment, and plans to escape (Lassiter, 1995).

While Frazier (1964) contends that "the black church" is a general term for many diverse ways of expressing the religious experience of African Americans living in the United States, Franklin and Mamiya (1990) define the black church as a network of shared institutions among Protestant Christian denominations, particularly the Methodist and Baptist churches. Washington (1972) includes the smaller, independent Christian churches such as Holiness, Pentecostal, and Spiritual churches, as well as black initiatives within predominantly white denominations such as the Roman Catholic and Episcopal churches. To this list, Hines and Boyd-Franklin (1982) add Jehovah's Witness, Church of God in Christ, Church of Christ, Seventh Day Adventist, Nation of Islam, Prebyterian, and Lutheran.

The black church, which serves as both preserver of the African-American heritage and agent for reform, is leading the African-American community's push to influence the future of

its families. Every black neighborhood and many non-black ones have black churches as a major institutional presence (Billingsley, 1992).

Billingsley states that the black church is the strongest and most representative organization in the black community, and that it "embraces traditional African-American values, identifies with both the struggles and achievements of African-American people, and it is institutionalized with an enduring organizational structure and mission" (p. 73). One reason it is difficult to generalize about the power of African-American churches is that they tend to be decentralized and autonomous. Most are doctrinally fundamentalist and socially conservative (Dalton, 1989).

Throughout much of American history, the Southern black church has been the institutional and symbolic center of the black community. Churches have provided locations for meetings and gatherings concerning collective issues and problems, settings for the development of black leadership, and various programs of mutual aid and community uplift (Ellison & Gay, 1990). Murphy (1994) notes that during segregation, the black church functioned as a "full alternative society," offering education, health care, and financial assistance to its members. The black church "often gave members the only avenue toward justice in the wider society, and it provided the network, leadership, and ideology for the quest for civil rights" (p. 156).

Within today's African-American community, the black church represents independence and respect for its leadership, and offers "the opportunity for self-esteem, self-development, leadership, and relaxation" within a community center and recreational center that encourages "education, business development, and democratic fellowship beyond its members" (Mays & Nicholson, 1969, p. 278).

In a 1986 lecture to the Association of Black Foundation Executives, C. Eric Lincoln commented that the function of the black church historically has included that of "lyceum, conservatory, forum, social service center, political academy, and financial institution" and "has been and is for black America the mother of our culture, the champion of our freedom, the hallmark of our civilization." Nichols (1987) found that a vital congregation "is one in which the redemptive and liberating power of the Gospel is applied with ever-increasing effectiveness to the real needs of people in the context of their personal and social situation in the world" (p. 109).

The Rev. Cecil Murray, pastor of the First AME Church of Los Angeles, commented that "the coming-to-church-for-personal-salvation days are over. Now we are looking not only for personal salvation but for social salvation . . . If we don't change the community, the community corrupts the individual" (Schneider, 1992, p. E1). Murphy (1994) concurs, noting that the "this-worldly" activities of the black church are not divorced from the "other-worldly" ones.

Billingsley (1992) warns that "it is a mistake to think of the black church in America as simply, or even primarily, a religious institution in the same way the white church might be conceived" (p. 352). In a survey of black congregations, Chaves and Higgins (1992) found that these groups were significantly more active than white congregations in civil rights activity and activities that serve underprivileged segments of the local community, such as community development, meal service, and public education on disease.

Among Southern blacks, religious commitment in the church has served as a gateway for full membership and participation in the black community (Ross & Wheeler, 1971). Because churches historically have been among the few institutions controlled by blacks, participation in

church-related activities has offered opportunities for social interaction and social status that were not available in white-dominated society (Lincoln & Mamiya, 1990).

Smith (1985) asserts that the black family and the black church have always drawn on each other for support and nurture, but they must first understand several shared realities before they can effectively develop cooperative strategies for dealing with community problems. These shared realities include "recognition that the black community is a suffering community, a community of extended families, an inclusive community, an adoptionist community, and finally, a hopeful community" (p. 25-28).

Cultural norms of communication

Oral traditions are long-standing traditions among African Americans (Edwards & Seinkewicz, 1990). African American culture values verbal skills, especially those couched in interactive and narrative frameworks. Oral tradition links speaker to audience, reinforces shared identity, norms, and values, fosters involvement of the audience through the use of metaphors and verbal and nonverbal response patterns (Hecht, Collier, & Ribeau, 1993), and functions as education, a validation of culture, wish fulfillment, and a force for conformity (Bascom, 1954).

Communication behavior patterns often differ between African Americans and white individuals. Kochman (1981) notes that the African American communication behavior mode tends to be "high-keyed, animated, interpersonal, and confrontational," while the "white middle-class mode tends to be relatively low-keyed, dispassionate, impersonal, characteristically cool, and lacking in affect." (p. 18)

The verbal skills and language competence of the African American oral tradition are learned at early ages. Erickson (1984) describes the tradition of "stylin'" or "show

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time" in which African American children are encouraged to be assertive and to showcase their verbal skills. Typically, an African American parent tells a child not to do something, and the child gradually intensifies his or her threats to do it anyway. As the child's threats become more and more drastic, the adults reinforce the verbal prowess of the child by saying things like "he so bad" and laughing approvingly and making other comments to positively reinforce the child.

In the classroom, African American youth tend to use a narrative form and style that includes a "topic associating" organizational frame that is usually not understood by white teachers (Edwards & Seinkewicz, 1990). In an ethnographic study of a multiethnic college class taught by an African American instructor, Foster (1989) found that the performance mode of both instructor and students was participatory, spontaneous, interactive, and the tone was perceived to be humorous. The instructor used gestures, metaphors, switching between mainstream and Black English, and language that was playful, figurative, and stylistically embellished. In her study of written storytelling among African American youth, Smitherman (1994) observed several key characteristics:

- Rhythmic, dramatic, and evocative language.
- Cultural references and references to color, race, or ethnicity, even when the topic does not call for it.
- Use of proverbs, aphorisms, and Biblical verses.
- A sermonic tone reminiscent of traditional black church rhetoric, especially in vocabulary, imagery, and metaphors.
- Direct address and conversational tone.
- Ethnolinguistic idioms, verbal inventiveness, and unique nomenclature.

- Community consciousness, including expressions of concern for the welfare of the entire community, not just individuals.

- Lack of personal distance from topics and subjects.

The oral tradition that originated in the African experience is enacted weekly in pulpits in black churches across the country. Given that the church plays an important role in African American ethnoculture, the conversational style of the black preacher is representative of the community, and sermon themes serve to reinforce community values and rules of appropriate behavior (Hecht, Collier, & Ribeau, 1993).

MacGaffey (1986) asserts that the key factor that distinguishes African from European theology is literacy or the literary exegesis of texts. In the black church, many texts of tradition are transmitted orally and ceremonially, including songs, prayers, rhythms, gestures, foods, emblems, and clothing (Murphy, 1994). Murphy notes that

> By insisting on the oral interpretation of the actions of the spirit, devotees ensure that only sanctioned people will transmit the teachings and that the transmission will happen only in face-to-face encounters between initiates and novices . . . Oral and ceremonial transmission makes for a smaller, tighter community, which, for all its drawbacks, might have benefits not to be found in communities dependent on literary exegesis (p. 183).

A culture's use of stories reveals themes and dimensions that identify the key symbols and reveal how social life is interpreted (Philipsen, 1987). Within a person's socially constructed reality, culture is learned through gaining understandings that are handed down in group experience, and it is transmitted through interaction with socializing agents (Lustig & Koester, 1993).

Bellah (1985) states that a "real community" is "one that does not forget its past" and added that

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In order not to forget that past, a community is involved in retelling its story, its constitutive narrative, and in so doing, it offers examples of the men and women who have embodied and exemplified the meaning of the community. These stories of collective history and exemplary individuals are an important part of the tradition that is so central to a community of memory. (p. 154)

Family norms

Dickerson (1994) argues that most past research about African American families has been done using traditional paradigms based on models of the dominant culture. This has resulted in the creation of stereotypes and misconceptions about "the black family."

The typical African American family is an extended kinship network (Staples, 1988), with each household consisting of at least four generations (Martin & Martin, 1978).

From the end of slavery through 1980, most African-American families have been married-couple families. Although more young African-Americans are delaying marriage than in past decades, the value placed on marriage is still so strong that most African-American youths and adults want to be married (Billingsley, 1992). Lewis (1967) argues that there is little need to teach values of marriage and stability to African-American youths, but rather they lack the conditions that make it possible to consummate and sustain the marital bond that they already value.

Nearly 15 percent of all black children are informally adopted without legal documentation, and about 40 percent of African-American families are "extended" in the sense that members of a nuclear family reside with other relatives and/or non-relatives (U.S. Bureau of the Census, 1990). Hill (1977) found that 90 percent of black babies

born out of wedlock are reared in three-generational families headed by their grandparents.

A norm of African-American family life is that people do not have to live in the same household in order to function as a family unit. The typical African American family is an extended kinship network (Staples, 1988), with each household consisting of at least four generations (Martin & Martin, 1978). Stack (1974) coined the term "fictive kin," which others call "play mother, brother or sister, aunt, uncle, or cousin." Billingsley (1992) commented that most black children "have so many 'aunts,' 'uncles,' and 'cousins' unrelated to them by blood that they can hardly keep track of them. Whenever they are in need, however, or reach a particular transition in their lives, they can count on assistance from these 'appropriated' family members" (p. 31).

African-American families have adopted a wide variety of family structures in an effort to resolve conflicting demands of society, as well as the spiritual, physical, economic, social, and psychological demands of family members. Billingsley created a typology of three major structures – nuclear, extended, and augmented families – as well as 12 different subtypes, depending on gender and marital status of family heads, and the presence or absence of children, other relatives, or non-relatives.

Numerous sociological studies, including Dressler, Haworth-Hoeppner and Pitts (1985), Payton (1982), and Cross (1982), have concluded that the female-headed, single-parent family is not a product of African-American culture or values. Rather, it has resulted from stresses and other forces in the wider society, particularly the struggle with unemployment, racism, and the welfare system.

The black single mother norm often has been blamed for the high rates of delinquency among African American youth. However, the negative behaviors of many African-American teens could be explained by their abandonment of family traditions, including religion, personal conduct codes, sexual codes, dress codes, and language codes. In addition, many of these teens are most susceptible to drug culture and gang life because of an increasingly pervasive street culture. Many black youths between 10 and 14 are just as susceptible as older teens to teen pregnancy and juvenile delinquency (Billingsley, 1992).

More young black males go to jail than to college. In a definitive report on the status of young black males, Gibbs (1988) concluded that they are "an endangered species," and commented that "in American society today, no single group is more vulnerable, more victimized, and more violated than the young black males in the age range of 15 to 24" (p. 219).

By the end of the 1980s, many family specialists, African-American leaders, public officials, and news media reports began to discuss the "African-American family crisis." Billingsley (1992) comments that "a growing sense of alienation or estrangement" among African-American families "leads to a hopelessness which often borders on despair" (p. 69). In rebuttal to these crisis discussions, Raybon (1987) wrote in *Newsweek* that:

> Day after day, week after week, this message – that black America is dysfunctional and unwhole – gets transmitted across the American landscape. Sadly, as a result, America never learns the truth about what is actually a wonderful, vibrant, creative community of people. Most black teenagers are not crack addicts. Most black mothers are not on welfare . . . I want America . . . to see us in all of our complexity, our subtleness, our artfulness, our enterprise, our specialness, our liveliness, our American-ness. That is the real portrait of black

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Americans – that we are strong people, surviving people, capable people. That may be the best kept secret in America. (p. 5)

Raybon's statement is supported by a number of studies of black family norms. Royce and Turner (1980) found that black families tend to place strong value on discipline and on teaching children to have self-respect and to be happy and cooperative. Christopherson (1979) found that black family norms also include love for children, acceptance of children born out of wedlock, strong resilience, and adaptability of family coping skills. Gary (1983) found that achieving black families of both single-parent and two-parent structures, as nominated by community leaders, tend to rely on values of strong kinship bonds and positive parent-child relations, as well as strong achievement, religious, intellectual-cultural, and work orientations.

On the other hand, youths who experience abandonment, substance abuse, domestic violence or sexual abuse at home, the absence of parental figures, destitution within single parent families, or who have parents who are substance abusers or convicted criminals face life stressors that predispose them to high-risk behaviors (Frankenberger & Sukhdial, 1994; Rotheram-Borus, Koopman, Haignere, & Davies, 1991; Sondheimer, 1992).

Young (1991) found that male teens from single-parent homes tend to engage in higher levels of sexual activity and begin having intercourse at an earlier age than males from two-parent homes. Black female teens from two-parent homes were less likely to be virgins than white female teens, but tended to engage in lower levels of sexual activity than sexually active white female teens from two-parent homes. Similarly, low-income black female teens without a

father at home tend to be more sexually active (Keith, McCreary, Collins, Smith, & Bernstein, 1991).

Message Design and Delivery

The "Message Design and Delivery" domain of the theoretical framework includes components of seven existing theories. Gerbner's (1956) General Model of Communication posits that "someone – reacts through some means – to make available materials – in some form – and context – conveying content – of some consequence." This statement implies that message design and delivery includes utilizes media channels and relies on the administration, distribution, and freedom of access to materials. Process variables include the structure, organization, style and pattern of a message, as well as the communicative setting, sequence of messages, content, and meaning.

A health message usually is designed to persuade an individual to change his or her behavior. The Health Belief Model (Becker, 1974) contains a "Cues to Action" component, which includes campaigns and interpersonal advice. According to the Elaboration Likelihood Model of Persuasion (Petty & Cacioppo, 1981), persuasion cues include self-presentation, demand characteristics, and source characteristics. The characteristics of a message source, according to the Input/Output Matrix (McGuire, 1989) include number, unanimity, demographics, attractiveness, and credibility. Characteristics of the message itself include the type of appeal, type of information, inclusion/omission, organization, and repetitiveness. Channel variables include modality, directness, and context. Finally, the destination variables of the Input/Output Matrix include immediacy/delay, prevention/cessation, direct/immunization.

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Communication variables of the Transformation Model of Communication (Kreps, 1994) include message strategies, language used, nonverbal cues, channels, and media. The Persuasive Health Messages Framework (Witte, 1995) posits that message goals include arguments, definition of the target audience, focus (i.e., "What is the threat to be prevented?"), behavior change objectives (i.e., "How will the threat be prevented" and "What recommendation will be advocated?") and cues (cultural values, colloquialisms, best channels, source preferences, literacy level, and customs related to sexual discussions).

Channel factors in Witte's framework are defined by the question, "Where do individuals prefer to get their information about HIV/AIDS prevention?" The cultural appropriateness of a message depends on whether it respects privacy and avoids embarrassment.

The Extended Parallel Process Model (Witte, 1996) distinguishes between the photographic and written components of threat and efficacy messages. The characteristics of threat messages that can affect their effectiveness include the vividness and neutrality of language, use of examples of susceptibility or severity, use of color vs. black-and-white images, to what extent the source emphasizes the population at risk, the extent that the response efficacy of the recommended behavior is emphasized, whether the message includes role-playing that answers questions, whether it lists typical excuses for non-compliance, whether it emphasizes the ease and benefits of compliance, and whether it refutes false beliefs or low-efficacy beliefs.

The following model, Figure 8, highlights key aspects of the design and delivery of AIDS prevention messages. This domain of the conceptual framework also discusses

how individual, cognitive, and social factors can influence the impact of a particular health message, particularly among African Americans.

Cues to Action

Cues to action, the stimuli which trigger an individual's decision-making process, include mass media campaigns, interpersonal interactions with peers or experts, nonverbal cues, or personal experience with AIDS, including previous practice of AIDS preventive behavior or the illness of a family member or friend. The "cues to action" concept is a basic component of Becker's (1974) Health Belief Model, which predicts compliance with

INDIVIDUAL PROCESSES
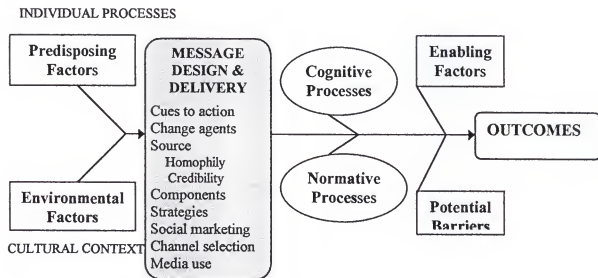
FIGURE 8: Characteristics of AIDS Prevention Message Design and Delivery

health behavior recommendations. It is particularly difficult to identify effective cues to action for young people because they tend to be inattentive to issues of morbidity and mortality, are being confronted by their emerging sexuality, and are heavily influenced by peer pressures (USCM, 1990).

Change Agents

Rogers (1995) defines a change agent as a person who "influences clients' innovation-decisions in a direction deemed desirable by a change agency," uses opinion leaders as his or her "lieutenants" in diffusion campaigns, and who is typically a professional with a university degree in a technical field (p. 27-28). Many change agents believe that an advantageous new idea will sell itself, that its obvious benefits will be widely realized by potential adopters and that it will therefore diffuse rapidly. However, history shows this is rarely the case.

Byrnes (1966) points out that change agents themselves can create resistance to change because of their communication style, through doing such things as:

- Giving orders rather than asking what and why people do what they do
- Preaching practices rather than teaching how and why
- Stressing methods rather than competencies
- Talking about rather than demonstrating practices
- Being inadequately prepared to teach

Source Characteristics

Homophily

Similarity between change agent and target population is an important determinant in the acceptance of an innovation (Lazarsfeld & Merton, 1964), and conversely, a primary barrier to effective diffusion is dissimilarity between them (Rogers, 1995). Homophily is the degree to which pairs of individuals who interact are similar in certain attributes, such as beliefs, values, education, or social status. Homophilous individuals share common meanings, a mutual sub-cultural language, and are alike in personal and social characteristics.

Rogers (1995) argues that to some degree, a lack of homophily must exist between individuals in order for any diffusion to occur. If two individuals had an identical technical grasp of an innovation, diffusion could not occur as there would be no new information to exchange.

Lack of homophily between AIDS message designers and African American audiences has resulted in limited effectiveness in reaching black communities. AIDS prevention efforts directed to black communities frequently have been hindered by the assumption that the messages need only be "translations" of public service announcements, pamphlets, and posters originally designed by and for white, middle-class audiences.

Beyond using the colloquialisms of African American sub-groups, messages should demonstrate an understanding of the realities of their everyday lives, as well as how race, ethnic diversity and culture permeate value systems and world view (Gleaton & Johnson, 1995).

In order to reach African Americans with a prevention message, change agents must be culturally competent. In other words, they must draw on community-based values, traditions, customs, and the expertise of knowledgeable people from the African American community.

Cultural competence helps change agents avoid harmful stereotypes and biases, use language and terminology that is meaningful and not offensive, understand the cultural differences and similarities within, among, and between African American subgroups, and focus on the positive characteristics of particular groups (NIDA,

1992).

The cultural adaptation model (Michal-Johnson & Bowen, 1992) posits that regardless of whether an AIDS educator is culturally similar to the target audience, he or she must conceptualize the message from the values and experiences of the intended audience, use a verbal style that the audience will find believable and persuasive, and identify with those elements of lived experience that are "normal" and part of everyday events.

Source Credibility

Legitimacy is crucial for community-based health campaigns because it is the process through which social leaders "give sanction, justification, and the license to act," influencing the rest of the community to adopt desired changes (Rogers & Shoemaker, 1971, p. 280).

According to consistency theories of attitude change, a person who has a negative opinion about an idea but a positive attitude about the endorser will be driven to reduce the tension created by the inconsistency. To reduce this tension, the person must assume that the endorser is not really enthusiastic or knowledgeable or must change his or her attitude toward the idea or endorser. If the audience has strong positive attitudes toward the endorser and the endorser is strongly linked to the idea, the audience will tend to improve its attitudes toward the idea (Batra, Myers, & Aaker, 1996).

Source credibility is enhanced by relationships that are trusting, open, and authentic and is facilitated by frank recognition and valuing of differences (Walker, 1991). A source must be knowledgeable about the values, assumptions, and identity

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issues of a target audience in order to achieve credibility (Banks, 1995).

Dimensions of source credibility include power, prestige (from past achievements, reputation, wealth, political power, or visibility), competence or expertise, trustworthiness, attractiveness, dynamism (Rarick, 1963), and similarity between source and receiver (Rogers, 1962). All things being equal, the greater the physical attractiveness of the source, the more a receiver will like the message and the stronger the persuasive impact will be upon the individual (Batra, Myers, & Aaker, 1996).

Seven kinds of sources tend to be particularly successful in their influence attempts: commercial authorities, celebrities, connoisseurs, sharers of interest, intimates, people of goodwill, and bearers of tangible evidence (Dichter, 1966). Zimbardo (1972) observed that parents, teachers, ministers, and counselors

> represent some of the most powerful "behavioral engineers" in this society. . . . They function with the benefits of socially sanctioned labels which conceal persuasive intent: parents "socialize," teachers "educate," priests "save souls," and therapists "cure the mentally ill." (p. 82).

Appropriate sources for African Americans

Familiarity with a targeted group is essential in selecting a credible person to deliver AIDS prevention information. To an African American adolescent, a well-known sports figure may be much more credible than a teacher or doctor (Kaiser, Manning & Balson, 1989). Two kinds of role models are considered especially credible among African Americans: the pioneer, who penetrates an area perceived as closed to blacks, to show it can be done, and the cultural hero, who is often renowned and one of the first blacks to achieve a particular distinction (Manns, 1992). Michal-Johnson & Bowen (1992) found that African

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Americans tend to view personal testimony as a more credible and persuasive piece of evidence than whites do.

Face-to-face interventions among African Americans are likely to promote trust and security if the appropriate sources and messages are used (Bowen & Michal-Johnson, 1989). A key component of any AIDS message is the use of culturally appropriate spokespersons and other information providers. Leigh (1995) notes that culturally competent providers "are perceived by the members of a given culture as being knowledgeable and respectful of their mores, language, and styles of help seeking" (p. 129).

In a video exposure experiment, African American women from housing projects were significantly more sensitized to AIDS, were more likely to have discussed AIDS with friends, to be tested for HIV, and to request condoms at follow-up if they had viewed a public service videotape in which the presenter was African American (Kalichman, 1993). Because African Americans often distrust white health service providers (Bowen & Michal-Johnson 1990; National Commission on AIDS, 1992; Weinman, Smith, & Mumford, 1992; Worth, 1990), the source of the message should be someone who is perceived as credible by them.

Message Components

Characteristics of abstinence messages

Abstinence is the most effective method of preventing pregnancy and the transmission of HIV and other sexually transmitted diseases. This is the only HIV prevention behavior recommended by most black churches, given that religious

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conservatism generally precludes the promotion or discussion of condom use. Cates and Hinman (1992) have criticized exclusive reliance on abstinence-based approaches to HIV prevention as "absolutist."

However, the churches' abstinence message can be part of a broader, community-wide AIDS prevention strategy. While churches promote an abstinence message, AIDS organizations and schools can disseminate a condom promotion message. These dual messages could be integrated into a single community campaign that emphasizes a non-confusing, rational decision-making approach targeting youth.

Several public health scholars have supported this dual approach. Roper, Peterson, and Curran (1993) argue that protection of individuals from AIDS will depend on a community's ability to effectively combine abstinence-based and condom promotion strategies. Mays and Cochran (1988) also support this view, contending that abstinence-based church interventions can serve as an important component in multilevel campaigns that fit into the natural context of the community.

The advice to delay sexual involvement is generally more reasonable advice for adolescents than to forbid all sex prior to marriage. Frost and Forrest (1995) note that teens who delay intercourse are more likely to have stable relationships, to make better choices of partners, and to be more skilled at communicating and at negotiating sexual behavior and contraceptive use.

Kirby (1997) argued that abstinence-only programs are especially appropriate for middle school and junior high youths. However, in an evaluation of nearly 80 peer-reviewed teen pregnancy prevention programs in the U.S. and other countries, Kirby was

unable to determine whether the abstinence-only programs actually delayed intercourse because 99 percent of these programs had significant methodological limitations that could have obscured program impact. These limitations included insufficient sample sizes, lack of long-term follow-up, improper statistical analyses, failure to use random assignment, failure to publish both positive and negative results, lack of behavior change measurement, inappropriate measures of behavior, and failure to use independent evaluators. Kirby argued that rigorous, well-designed research is needed to assess effectiveness of abstinence programs.

The "Not Me, Not Now" pregnancy prevention campaign of Monroe County, New York emphasizes the messages that "abstinence makes sense for your future," teen pregnancy has severe consequences, and that "it's OK – even cool – to say no to sex" (Doyle, 1997).

A pre/post-test survey designed by program coordinators to evaluate the effectiveness of the program showed that a significantly higher proportion of youth said it is OK for people to start having sex when they have a good job and can support themselves and a baby. This reflected an increase of 5 percent over the 22 percent who asserted this view in the first survey. However, there was no change in the proportion who said they would wait until marriage (37 percent) or until they were living with someone (8 percent).

Roper, Peterson, and Curran (1993) argue that adolescents will not be persuaded to postpone sexual activity unless educators can create

> A climate supportive of young people who are not having sex and so help to create a new health-oriented social norm for adolescents and teenagers about sexuality. As we proceed toward this objective, we must be mindful that many will continue to engage in sexual activity. It is essential that these youngsters receive the message that they must practice safer sex and use condoms (p. 4).

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Adolescents who already are sexually active may be less likely than virgins to postpone sexual involvement as an HIV prevention strategy because compliance with the advice requires behavior change rather than mere behavior maintenance. However, an abstinence message targeting sexually active teens could emphasize the emotional, spiritual, and physical benefits of postponing further sexual involvement.

A number of teen pregnancy prevention programs have shown that an abstinence message reinforced by interpersonal interaction can be an effective component of a comprehensive prevention campaign. In order to succeed, an AIDS prevention program targeting hard-to-reach youth must be comprehensive, intensive, and include one-on-one sessions (Rotheram-Borus, Koopman, Haignere, & Davies, 1991). A review of five rigorously evaluated teen pregnancy prevention programs (Frost & Forrest, 1995) showed that all incorporated an emphasis on abstinence or delay of sexual initiation, training in decision-making and negotiation skills, and education on sexuality and contraception. Of the four programs that measured changes in rates of sexual initiation, all had a significant impact on that outcome, especially when targeting younger teens.

The "School/Community Program" in South Carolina, based on concepts of adolescent decision-making, self-esteem, communication, and influences on sexual behavior, targets rural, mixed-race, low-income girls. The program recruited clergy, church leaders, and parents to attend mini-courses and used a community newspaper and radio campaign to spread its messages (Vincent, Clearie, & Schluchter, 1994).

"Postponing Sexual Involvement," an abstinence-based, eighth-grade curriculum in Atlanta based on social influence and social inoculation theories, targets low-income, urban black teens. Eleventh and twelfth grade students lead the teens in activities to help

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them identify the source of and motivation behind pressures to engage in risky behavior and assist them in developing skills that will help them resist such pressures.

While the "Postponing Sexual Involvement" program strongly emphasizes abstinence, it also includes education about sexuality, contraceptives, and life skills (Howard & McCabe, 1990). "Life skills education" includes instruction about decision-making, goal setting, saying no to sex, and negotiating within relationships. The activities often include role-playing exercises in which students act out various situations they might encounter (Frost & Forrest, 1995).

"Teen Talk," a school and community-based curriculum based on the health belief model and social learning theory, targets low-income boys and girls from mixed racial and ethnic backgrounds. The program includes sessions designed to alter teens' behavior by raising awareness of their own attitudes, beliefs, and knowledge about the probability that they might personally become pregnant or cause a partner to become pregnant, the serious negative consequences of teen parenthood, the personal and interpersonal benefits of delayed sexual activity and consistent, effective contraceptive use, and the psychological, interpersonal and logistical barriers to abstinence and consistent contraceptive use (Eisen & Zellman, 1990).

Of the teens that received the "Postponing Sexual Involvement" or "Teen Talk" curricula, boys were more likely than girls to remain abstinent during the course of the intervention. While this outcome was unexpected, Frost and Forrest (1995) speculate that this may have happened because support for abstinence is seldom given to males in our society. Further, role playing and interactive discussions may have encouraged boys to think about their relationships in new ways (Eisen & Zellman, 1992).

Cultural Relevance

Using appropriate cultural symbols in a prevention message is an important strategy for reaching African Americans. While the "America Responds to AIDS" campaign was criticized for its overall culture-free approach, it did include graphics of a church building and a grandmotherly figure wearing a crucifix to symbolize the religious institution as a central but noncontroversial part of the cultural context (Michal-Johnson & Bowen, 1992).

Swanson (1993) criticized the "America Responds to AIDS" public service announcements as being:

> A fragmented mix of unfocused communication efforts. . . . Rather than uniting members of our American "melting pot" to fight HIV infection and AIDS, the TV and radio spots actually divide the population by reinforcing existing community stereotypes and excluding the members of already disenfranchised groups from the fight against the disease. (p.2)

General principles of message effectiveness can be applied in the development of culturally appropriate AIDS prevention campaigns. Banks (1995) argues that message effectiveness is assessed by the degree to which the communication:

- Reinforces the self-concept of participants
- Affirms cultural identities
- Enhances relationships between parties
- Accomplishes strategic goals of both parties
- Recognizes the contextual nature of meanings
- Accepts the diversity of interpretations
- Remains open to reinterpretation

In addition, AIDS messages should emphasize how HIV is transmitted in a particular community, in this case the African American community, and how each member of that community can help prevent further transmission.

Message Strategies

Social marketing

Social marketing, the application of commercial marketing strategies to the diffusion of nonprofit products and services, was launched about 45 years ago with the rhetorical question, "Why can't you sell brotherhood like you sell soap?" (Wiebe, 1952). This approach has been applied to AIDS prevention, as well as smoking cessation, safer driving, decreasing infant mortality, family planning, drug abuse prevention, anti-littering, and weight loss.

Rogers (1995) notes that social marketing is usually aimed at the poorest and least educated, who are likely the most difficult to reach. Yet, change agencies often expect a high level of reach and rate of change as a result of these campaigns.

A barrier to social marketing effectiveness is competition for attention in the public arena. A social condition is problematic only when someone or some group defines it as a problem or threat (Edelman, 1964; Cobb & Elder, 1983). Definitions or frames of social problems compete for acceptance and attention in the public arena and do not reflect objective or non-controversial assessments of conditions (Hilgartner & Bosk, 1988).

The essential elements of a social marketing campaign, according to Rogers (1995) are audience segmentation and formative evaluation research, as well as positioning relative to the intended audience's meanings and use of various communication channels.

Most AIDS prevention social marketing campaigns in the past have promoted condom use, emphasized fear appeals, featured dramatizations of heterosexual

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relationships, made statements about drug use or infidelity, or provided sources of information about AIDS (Ellerbrock, Lieb, Harrington, Bush, Schoenfisch, Oxtoby, Howell, Rogers, & Witte, 1992).

The usual approach to solving a social problem is to "blame the victim" by engineering ways to change individual behaviors rather than addressing the systemic roots of the problem itself (Dervin, 1980). Audience segmentation is based on the concept of individual behavior change.

Banks (1995) argues that society is always communicated with in segments, as targeted special-interest publics. Grunig and Hunt (1984) contend that relevant publics should be identified by aggregating people into groups on the basis of their perspectives on an issue, rather than merely segmenting a geographic population by race, age, or gender. This kind of segmentation includes assessment of how aware people are of an issue, how relevant they perceive the issue to be to them, and what control they believe they have over changing the issue.

Channel selection

Hertog, Finnegan, and Fan (1996) note that most campaign effects studies have concluded that mass media are more efficient than interpersonal channels for generating simple cognitive outcomes such as awareness and knowledge of simple skills, but interpersonal communication tends to be more effective in inducing attitude or behavioral change. Print channels are more effective in disseminating complicated information, while broadcast channels are better in generating awareness of a campaign and in disseminating simple messages

In the Stanford Three-Community Study, one community was treated with a heart disease prevention campaign using only mass media channels, another with a media campaign supplemented by face-to-face instruction of high-risk groups, and a third received no treatment. The strongest campaign effects were seen in the community where the media were supplemented by interpersonal communication (Maccoby & Solomon, 1981).

Campaigns are more likely to influence behaviors if they are well conceived, repeated over time, and reinforced through interpersonal intervention (Levin, 1987). Media-only health campaigns may be effective in short-term change in knowledge but usually have little impact on health behaviors that have been ingrained over a lifetime and which are strongly reinforced by individuals' lifestyles, reference groups and family structure (Brown & Einsiedel, 1988).

Freire's (1968) community action approach is philosophically similar to the two-way symmetrical model cited in the public relations literature. Grunig and Hunt (1984) posit that this model is one of four that have become standard approaches to campaign development:

- *Press agentry model*, which aims propagandistic information in one-way dissemination to a constituency to achieve interest, awareness, or motivation.

- *Public information model*, which assumes truthful information is communicated in a one-way process but without persuasive intent (McQuail, 1993).

- *Two-way asymmetrical model*, which assumes persuasion, but the communicator collects information about the audience up front or as feedback.

- *Two-way symmetrical model*, in which the communicator and audience share initiative and power. The audience accepts ultimate responsibility for driving an intervention and provides formative input and feedback so that the communicator

can conduct continuous research in order to develop a campaign based on mutual needs and benefits (Grunig & Grunig, 1992).

Appropriate channels for African Americans

Intervention strategies may not effectively reach high-risk individuals in the black community unless they incorporate nontraditional media and face-to-face delivery strategies. For campaigns targeting African American teens, these individuals can be most effectively reached at such locations as street corners, homes, churches, housing projects, shopping malls, community recreation halls, rap concerts, arcades, public agencies, group homes, court-related facilities, hospitals, and clinics (Stryker, Coates, DeCarlo, Haynes-Sanstad, Shriver, & Makadon, 1995).

In addition, outdoor media may be effective in reaching those who have limited access to television or newspapers. Transit posters at places where teens congregate can provide toll-free numbers for relevant health and community service organizations. Aside from multimedia campaigns, past interventions incorporating interpersonal intervention strategies have included HIV antibody testing with pre-test and post-test counseling, syringe exchange, street outreach, condom handouts to prostitutes and drug users, and other forms of peer education (Stryker, 1995).

Another strategy in developing an interpersonal component for a community AIDS prevention campaign targeting African Americans is to encourage individuals to obtain information about AIDS and risky behaviors from doctors or public health workers. Coverdale (1990) found that 92 percent of physicians who provide primary care for minorities believe they should educate their patients about AIDS, but in actuality these doctors reported giving advice to only 11 percent of their male patients and 14 percent of their female patients. A local AIDS

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prevention program could include a workshop for physicians in which they learn communication skills that could make them feel more comfortable discussing sexual issues with minority patients.

Fotonovela **as alternative campaign channel:** The *fotonovela*, a Latin American soap opera or serial story script presented with photographs in a comic-book format, can be adapted for use as an innovative, culturally appropriate health promotion tool to target a variety of audiences. Flora and Flora (1978) define a *fotonovela* as "a love story told in photographs with balloon captions presenting the dialogue," and these booklets "both shape and are shaped by the dominant values" of the audience members (p. 135).

Fotonovelas have become a highly effective means of disseminating a variety of educational messages to Hispanic audiences throughout Mexico, Latin America, and the U.S. (Conner, 1991). The *fotonovela* is a micro-media channel, as are brochures, comic books, posters, lapel pins, and T-shirts. Micro-media channels, a component of micro-marketing strategies, do not disseminate a message or materials through media organizations, as contrasted with mass media channels such as newspapers, radio, magazines, and television.

In describing the use of photonovels in Peace Corps projects in third-world countries, Weaks (1976) asserts that the photonovel

> has permitted access where other media have failed; it has filled in the gaps where more traditional, and often more expensive media have introduced ideas but without great and lasting impact. It is more important as a means of information dissemination and as a catalyst for audience participation. (p. i)

The *fotonovela* was long unnoticed as a campaign channel, partly because of "the profusion of poorly designed and executed posters, pamphlets and brochures that have

bombarded the public in the past" (Weaks, 1976, p. 2). During the early 1970s, the Peace Corps tried to reach isolated peoples in Ecuador using flipcharts, posters, and filmstrips. However, the organization abandoned these methods, after trials, in favor of the photonovel "because of its ability to communicate a detailed message through words and vision, while entertaining at the same time" (Weaks, 1976, p. iv).

Televised public service announcements have been used massively in the service of various public health goals, including AIDS prevention (Lorch, 1994). However, many PSAs fail to reach individuals because they are aired too infrequently, outside prime time, or on noncommercial stations; many are directed at unidentifiable audience segments; and most do not account for the attitudes, values, and norms that affect exposure to PSA messages (Flay & Sobel, 1983). Compared with traditional broadcast-format public service announcements, educational *fotonovelas* have many advantages. According to Weaks (1976) and others, *fotonovelas* typically are:

1. Less expensive to produce than radio, television, or film productions.

2. More likely to remain in the readers' possession and less likely to be discarded.

3. More effectively disseminated to a target audience because of their greater potential to circulate within existing community networks.

4. Better able to explain information in detail, emphasize key points, and outline procedures.

5. More culturally sensitive and culturally relevant.

6. More realistic because the photographs help the reader more readily identify with the characters.

7. More likely to be in demand among those who read similar materials for entertainment.

8. More fun to read because pictorial content, simple dialogue, and an interesting story create an atmosphere conducive to learning.

9. More effective in creating and maintaining norms, through social modeling and interpersonal reinforcement of the message within communication networks.

10. More appealing to lower-literacy individuals because the language is more readable, familiar, and comprehensible. Rather than feeling pressured to learn, the reader can absorb information without conscious effort.

11. Better able to "sell ideas" because the story shows readers the "how" and "why" of an idea and illustrates how he or she may benefit as an individual.

12. Better designed, particularly when audience members help in producing them.

13. Effective in conjunction with other media in a communications campaign because it can fill in informative details too lengthy to include in radio, TV, or posters.

14. More user-friendly in that electronic equipment such as a television, radio, computer, or film projector is not needed and because audience members can read it at their convenience.

When used as an educational tool, *fotonovelas* also have several disadvantages when compared with other media (Weaks, 1976, p. 4):

1. The content is static because it is more difficult to change without costly adjustments.

2. Close teamwork is required, which means that writers, photographers, actors, and printers must be cooperative.

3. Thousands of copies must be printed so that the cost per booklet is not prohibitive for free or low-cost distribution.

4. They are not accessible to non-literate audiences or to individuals with poor eyesight, even though they are appropriate for semi-literate readers and can be read aloud to those who cannot read.

The literary *fotonovela* originated as an entertainment form in North Africa and Europe and was introduced into Latin America during the 1940s (Conner, 1991). The early Mexican *fotonovelas* retold the action of a melodramatic love story with

photographic stills of popular movies and dialogue contained in balloons (Flora & Flora, 1978). In a *fotonovela*, "captioned photos present male-female relations in the melding of visual exactness and audio imagination" (Flora, 1980, p. 524).

By the 1970s, 23 weekly *fotonovela* titles – with as many as 350,000 issues of a single title printed – were distributed in more than 7,000 newsstands in Mexico (Herner, 1979). A popular version of the *fotonovela* in Europe, the French *photoroman*, originated in the mid-1930s as an offshoot of the general women's magazine and often presented each dramatic serial in a pocket-size format for three to six months (Nye, 1977).

In Mexico, the audience members for *fotonovelas* are usually semi-literate, working class women. Surveys of *fotonovela* readers indicate that the vast majority has few appliances and is, therefore, assumed to be in the lower socioeconomic classes (Habert, 1974). The traditional *fotonovela* sold in Latin America may particularly appeal to women from lower socioeconomic backgrounds because the narrative reinforces long-accepted sexual mores. Acosta (1973) identified six types of female characters portrayed in *fotonovelas*: (1) erotic objects, (2) voracious devourers of men, (3) virginal girlfriends and fiances, (4) chaste faithful wives, (5) saintly mothers, and (6) meddling mothers-in-law. In their analysis of 62 Spanish-language *fotonovelas*, Carrillo and Lyson (1983) found five major themes: marital/premarital morality, beneficent fate, conflict in family relationships, sexual taboos, and social success stories.

Women are not the exclusive readers of romantic *fotonovelas*, however. In a content analysis of 200 pen pal request letters published in a Mexican *fotonovela*, Flora

(1980) found that most letters were from adolescent boys and girls, and a third were from males.

Fotonovela **Design and Delivery:** A *fotonovela* has greater potential to empower target audience members to reduce their health risks if it is culturally appropriate, effective, and affordable (Ricardo, 1996). Effective *fotonovelas* typically feature "cultural sensitivity, relevant contexts, powerful role models, and an entertainment format" (Ricardo, 1996) and are appropriately geared to the culture, ethnicity, race, gender, language, and class status of the learners (Rudd & Comings, 1994).

The effectiveness of a *fotonovela* depends in part upon its production and aesthetic value. If a reader can visually see that a *fotonovela* is about his people, and especially if he has rarely seen stories written about his people, he likely will read the *fotonovela* on the basis of visual content even if the message is of no interest to him (Weaks, 1976). Baetens (1989) asserts that

> Since the photographic novel belongs to two distinct artistic domains, it must be submitted to a plurality of judgments: It lends itself to a literary appreciation and, moreover, it does not escape from a photographic evaluation. (p. 286)

From a purist's point of view, however, *fotonovela* photography may not be truly artistic. Baetens observes that the photo novel is "fake," in that

> Its producers fail to watch and wait for the miraculous instant in which "true" photographs are taken. The shift from the single photograph to a constructed series of images, together with all the artifices that result from staging, montage, and editing necessarily disqualify the genre in view of the dominant photographic ideology. (p. 287)

Nye (1977) noted that most *fotonovelas* use cinematic-style photography, including

A careful blend of close-up, medium, and long shot . . . emphasizing the dramatics of the posed situations. . . . In effect, the arrangement of pictures on the page is intended to resemble a succession of movie stills, each advancing the action a step. (p. 746)

Weaks (1976) argues that the visual content of a *fotonovela* is more likely to hold a reader's attention if the photographs reflect three types of viewpoints in the way that they compose various scenes:

- The *establishing* photo shows the environment in which the action occurs (i.e., room, house, or landscape). Tells the "where" of the story.

- The *close-up*, which closely frames a character's face or object of interest. Tells the "who" or "how" of the story.

- The *medium close-up* shows the immediate situation. The emphasis shifts from the subject to its activity, which may involve more than one person. Tells the "what" of the story.

Another dimension of *fotonovela* effectiveness is its readability, including its ability to appeal to a reader's interest. Nye (1977) found that the dialogue is usually simple, with limited vocabulary and short sentences. The settings are places "where people meet and things happen" (p. 746). A unique characteristic of many *fotonovelas* is their pocketsize format, which "aids readership of this 'deviant' material, which can be easily concealed in newspaper or schoolbook" (Flora, 1980, 525).

Weaks (1976) recommends that a *fotonovela* writer:

- Create a plot that is easily understood by the audience.

- Avoid using "sophisticated gimmicks such as flashbacks or leaps through time."

- Keep the cast to a minimum of those needed to carry the plot to a conclusion and convey the message (usually three to five characters).

- Clarify scene changes.

- Set the dialogue apart from photographs by using balloons and/or narrative inserts.

- Use appropriate colloquial expressions and other dialect.

- Pre-test the narrative if any material might be scandalous or otherwise sensitive (p. 9-10).

A major cost-saving aspect of a *fotonovela* intervention is that it can be implemented by community volunteers or other non-professionals. *Fotonovela* delivery methods should be interactive and varied, depending on the characteristics of the target population (Gromley, 1996).

A *fotonovela* can serve "as a cultural bridge between an impersonal, unfamiliar, and often alienating environment and the more familiar heritage of the readers" (Carrillo & Lyson, 1983, p. 59). It also can serve "as a convenient mechanism to establish and maintain a common set of norms and values" among members of a large segment of a population (Acosta, 1973, p. 29).

One way of creating and maintaining norms among targeted readers is to involve audience members in developing a *fotonovela*. In Ecuador, researchers involved learners in developing *fotonovelas* in order to stimulate discussion and to help participants discover themselves as the agents of change (Center for International Education, 1975).

Similarly, the Chiapas Photography Project, a Mayan cultural cooperative started in 1992, teaches natives of highland Chiapas, Mexico, to produce *fotonovela* presentations of their plays and other works about their ancestry and everyday lives. For example, one shepherd in the artists' cooperative recorded and illustrated 47 traditional rules and beliefs that guide the eating and health habits of her people,

So that the roots of our ancestral culture [can] be known by the new generation, above all by the children, because they are those who suffer most from the cultural changes of our people. (Nifong, 1994)

Overall, the purpose of the Chiapas project is

To make available to indigenous artists the technical resources they need to express freely their creativity. No artistic or cultural guidance is provided that might influence in any way the photographers' work (America, 1994).

On Dec. 22, 1997, para-military men massacred 45 Mayans in Chiapas, Mexico, as the villagers gathered in worship at church. Like the Africans brought to America, the Chiapas people are the victims of ethnic genocide. However, their expressions of creativity, tradition, and heritage within their *fotonovelas* may truly be, as Freire (1961) envisioned, a "pedagogy of the oppressed" and a lasting vestige of their culture.

Ricardo (1996) found that the most influential aspect of a *novela*, as an educational tool, is that readers often engage in interpersonal dialogue about the story. The social interest generated by the characters, photos, and story promotes conversation among those who read, hear, or see the *novelas*. As participants disseminate *fotonovelas*, the educational impact is bolstered through social interaction (Gromley, 1996). Detectable, positive effects of a *fotonovela*, including behavior change, usually require three to four weeks (Ricardo, 1996).

Through in-depth interviews with Latin American adolescents, Flora (1980) found that most begin reading *fotonovelas* at around ages 9 or 10, and those who spend the most time reading them are 14 or 15. Flora observed that *fotonovela* reading among adolescents is often a group function, in which

Friends will get together with a pile of *fotonovelas* and read them as they trade back and forth. A social invitation may consist of "Come over and read *fotonovelas*." Like watching television, little interaction occurs for most readers.

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But doing it together creates a non-verbal sharing of a series of important values, especially those relating to interpersonal relationships, the relative importance of romantic versus other problems, and the method through which problem solution is achieved. Thus writing to *fotonovelas* can be seen as a continuation of the social process of *fotonovela* reading (p. 530).

In Latin America, most working-class neighborhoods have at least one "entrepreneurial" woman with a rental library of *fotonovelas* (Flora & Flora, 1978). In Ecuador, many "lunch hour libraries" rent *fotonovelas* by the hour, and "the service is so popular that one sees a city park blanketed with lounging workers, each with a photonovel in hand" (Weaks, 1976, p. 1). Flora and Flora (1978) observed that "within a household, all family members are likely to read a purchased volume, and both blood and fictive kin borrow the *fotonovela* frequently" (p. 136). Weaks (1976) notes that a *fotonovela* "is guarded as a possession worthy of great care" (p. 2).

***Fotonovela* as Health Education Tool:** The use of drama has been shown to improve the outcomes of health education and communication skills among nursing students (Riseboroughyh, 1993). *Fotonovelas,* as well as *radionovelas* and *telenovelas,* have been used in the United States and in Latin American countries to communicate health information to the public on such topics as AIDS, diabetes, and substance abuse, as well as other social issues that are not directly health related (Gromley, 1996). The earliest educational photonovels in Ecuador, produced by the Peace Corps, addressed environmental sanitation, pre- and post-natal nutrition, malaria control, and family planning (Weaks, 1976).

To reach Long Island's Spanish-speaking population with a campaign to combat drunken driving, several counseling and educational agencies teamed to produce a bilingual *fotonovela* titled "*La Pesadilla*" (The Nightmare), also used as a classroom text

(Business Wire, 1995). Safeway grocery stores and the California Highway Patrol recently used bilingual *fotonovelas* to disseminate information about child lead poisoning prevention (Business Wire, 1995). The city of Santa Ana, California, won a national award for producing a *fotonovela* and accompanying video in three languages titled "Good Home, Good Neighbors" to help recent immigrants learn the "do's" and "don'ts" of their new city (Henry, 1995).

Century Council, a Los Angeles-based alcohol abuse program funded by the alcohol industry, created a *fotonovela* titled "*Si Toma, No Manaje*" (If You Drink, Don't Drive) to educate Hispanics about drunk driving. The fotonovela was one component in a campaign that also included PSAs, posters, buttons, and materials encouraging alcohol vendors to check I.D.s to prevent underage purchases (Alcoholism & Drug Abuse Week, 1992). Similarly, the California Highway Patrol created a drunk-driving *fotonovela* and accompanying video *telenovela* titled "*El Protector*," featuring a superhero portrayed as

> A calm, benevolent figure with an understated macho presence, . . . a CHP officer dressed in a black leather jacket and sunglasses, wearing a mustache and slicked-back hair – or whatever fashion statement is considered cool at the time (Regalado & Bustillo, 1993).

Many *fotonovelas* also have been developed to educate Hispanic patients about various illnesses and treatments. For example, *fotonovelas* with such titles as "Qe le pasa a abuelito?" (What's Happening to Grandfather?) and "*Unidos en la Lucha*" (United in the Fight) have been developed to educate Hispanics about Alzheimer's disease (Aging, 1992). A number of American drug companies have developed *fotonovelas* targeting Hispanic patients. Burroughs Wellcome, a company that produces retroviral drugs for HIV-positive patients, converted a traditional physician's flip chart into a culturally

relevant *fotonovela* containing Spanish-language testimonials and custom-tailored illustrations. The company interviewed patients, physicians, and AIDS service organization counselors, all of whom were Hispanic. In addition, the company involved these participants in every step of the process of creating the materials (Lipton & Lipton, 1995).

Pratt Pharmaceuticals and Roerig Inc. developed a series of bilingual *fotonovelas* titled *"Su Salud Su Futuro"* (Your Health, Your Future) to educate patients about treatments for diabetes, hypertension, and depression. The companies supply the *fotonovelas* free of charge to physicians, who then may distribute the materials to appropriate patients. Pratt and Roerig used the *fotonovela* format as a tool

> To reach the mass undiagnosed Hispanic market with a message on the risk factors and warning signs of diabetes. . . . (and) to deliver the educational message in an interesting, friendly, and approachable manner (Lipton & Lipton, 1995).

The only known targets of previous AIDS prevention *fotonovela* interventions are low-literacy Hispanics, particularly migrant farm workers. A number of *fotonovelas* targeting these individuals have been disseminated by outreach workers, health clinics, and churches. For example, as part of an informal AIDS clinic in the heart of the Latino community in Santa Ana, clients received HIV prevention *fotonovelas* geared to lower literacy audiences (Reyes, 1993).

In the first published evaluation of an AIDS *fotonovela* intervention, Conner (1991) examined changes in knowledge, attitudes and behavior as the result of a California intervention targeting young male, Mexican migrant workers. *"Tres Hombres sin Fronteras"* ("Three Men without Borders") told a story of three farm workers who

left their families in Mexico to work in the fields of the United States. The program involved two types of formats: a *fotonovela* consisting of an eight-page, tabloid-sized booklet and a 15-segment *radionovela* (five minutes each segment). The *fotonovela* also includes a mini-*fotonovela*, "*Marco Aprende como Protegerse*" ("Marco Learns How to Protect Himself"), which explains how to use, dispose of, and obtain a condom and which includes several condoms for practice and use.

The *fotonovela and radionovela* tell the story of three men who leave their families to cross the Mexico-U.S. border and work in the agricultural fields. After work, they meet prostitutes who inform them about AIDS risk and how to prevent it by using condoms. The worker who refuses to use condoms discovers that his wife and baby, who remained in Mexico, are sick and infected with HIV. The worker who learns to use condoms and the one who abstains from sex remain healthy. Folk and modern medical personnel play roles in the story as AIDS information disseminators. Conner asked farm workers to assess the acceptability, appropriateness, cultural sensitivity, and clarity of the content. Pre-and post-intervention interviews of 52 men, as well as 37 men in a control group, were used to assess the effectiveness of the *novela*s. The pre-test included an assessment of AIDS knowledge. More than 80 percent read the *fotonovela*, and 68 percent correctly identified messages contained in each of the three *fotonovela* frames tested. When asked if they could protect themselves against HIV, almost twice as many men (90 percent) said "yes" after the intervention than before exposure to it. In addition, a significant increase in condom use was reported.

Ricardo (1996) found that the use of *fotonovelas* within this population resulted in faster behavior change than the use of *radionovelas* aired as a serial in multiple

segments. *Fotonovelas* also have been more effective than traditional brochures. In measuring readership of a locally produced AIDS prevention *fotonovela* compared to a more traditionally formatted and illustrated booklet, Mickiewicz (1991) found that the local *fotonovela* was more effective in increasing farm workers' AIDS-related knowledge and in changing their attitudes and practices toward less risky sexual behavior.

Ricardo (1996) developed a health promotion *fotonovela* that targeted Latina women in migrant and seasonal farm worker populations who were enrolled in prenatal care programs. Ricardo found that these women tended to have difficulties adopting risk reduction strategies because they lacked access to relevant information and medical care, a migratory lifestyle, and various cultural and spiritual barriers. The *fotonovela* scripts were designed to reduce behavioral risks, including lack of knowledge of sexually transmitted diseases and HIV/AIDS, low perceived risk regarding HIV because of limited information, cultural myths, and illiteracy. Among migrant farm workers, exposure to *novela*s resulted in increased requests for condoms and increased interest in HIV issues among participants. Ricardo (1996) argued that the effective *novela*s were designed to

- Increase understanding among migrant women about the risk of HIV transmission.

- Increase condom use, which was the primary behavior change goal.

- Increase individual self-efficacy.

- Provide information in a way that low-literacy individuals can comprehend it.

- Create an information-sharing norm among members of the target population.

- Facilitate community participation in and ownership of effective intervention strategies.

- Provide positive role models to women.

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- Establish effective partnerships with community organizations to create and disseminate *novelas*.

Opportunities for an African American AIDS *fotonovela*: A major challenge in developing effective AIDS prevention interventions among African Americans is overcoming barriers of low literacy skills and cross-cultural communications. To be culturally sensitive, specialized AIDS interventions for African Americans should use language familiar to the recipients and use visual messages (Wofsy, 1987).

Gromley (1996) found that African American focus group participants identified soap operas and other dramatic presentations as effective methods of education. This interest in drama, combined with the strong tradition of storytelling in African American culture, creates a strong rationale for the use of *fotonovelas* in AIDS prevention efforts. An example of a program that draws upon the African American oral tradition is a STD prevention intervention designed by Solomon and DeJong (1986). They designed soap opera videos for the CDC that specifically targeted inner city black men who used STD clinics.

If the emotional appeal of traditional *fotonovelas* were culturally adapted for African Americans, it might boost their popularity in the black community. Carrillo and Lyson (1983) observed that most Latin American *fotonovelas*

> Offer an escape into both a cultural and linguistic milieu that is familiar and reassuring and into a fantasy world that provides the reader with vicarious sexual titillation. (p. 59)

In conducting focus group interviews with African Americans, Gromley (1996) found that a short leaflet or poster is more culturally appropriate for targeting the black community than the much longer, book-length *fotonovela* used to target Hispanics. This

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observation also is supported by research about pro-social television. Paulson (1974) found that the short segment format of television programming is generally more effective in promoting pro-social behaviors among African American youth than a longer format, possibly because an individual's attention span may be influenced by the short formats used in most television programming.

Many AIDS prevention interventions that have not specifically used a *fotonovela* have nevertheless utilized drama as an important component of outreach to youth. For example, as part of an urban AIDS intervention program, Rotheram-Borus, Koopman, Haignere, and Davies (1991) invited runaway minority teens at public shelters to participate in video and art workshops. The youths developed soap opera dramatizations, public service announcements, commercials, and raps about HIV prevention.

Similarly, in developing the "Not Me, Not Now" abstinence-based pregnancy prevention program for youth, Monroe County, New York, interviewed minority youth about their feelings and perceptions about sexual activity, their parents, future plans, and dreams, then used these comments as the basis of television and radio scripts. This strategy allowed the PSA designers to make the stories relevant and the language natural and authentic (Doyle, 1997).

The *fotonovela* **framework**: Analyzing the plots of *fotonovelas* can illuminate the social meaning of the stories presented, show what the characters generally do, and reveal prescriptive norms of proper and improper behavior and aspirations. Following Wright's (1975) structuralist method of textual analysis, Flora and Flora (1978) identified two types of plots in 90 percent of 78 selected *fotonovelas*: "individual love rewarded" and "mutual love rewarded." In both these plots, "it is the state of loving, not necessarily

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a specific action, which takes control of the situation and brings about the solution to the specific problem" (p. 140), and both plots "stress passivity, mobility-adaptation, and individualism in support of the status quo" (p. 149). Regardless of the plot type, the *fotonovela's* narrative structure

> Is such that no matter what the theme, individual sources of problems and individual solutions are stressed. . . . Vital plot devices must resolve the individual crises of lovers, not the structural conditions surrounding the couple. . . The survival (of *fotonovelas*) depends upon mirroring the values that support that type of system. (Flora & Flora, 1978, p. 141, 149)

Romantic emotion is the core of the photo novel narrative. To quote Barthes (1982), the principal characteristic of the genre is a "silliness as touching as it is traumatizing" (p. 59). While love is the "common, persistent, inexhaustible ingredient" of the photo novel, the booklet often features such "real-life" themes as: "true love doesn't run smooth, life is filled with traps, a good man is hard to find, . . . people make mistakes, happiness doesn't come easily, don't expect too much" (p. 745, 747). Regardless of which face of love the story presents, "virtue eventually wins, sin is punished (or forgiven under the proper circumstances), the rewards of fidelity are certain" (Nye, 1977, p. 747).

Similarly, in her analysis of Mexican and Colombian *fotonovelas*, Flora (1980) found that 30 percent start with the characters knowing each other, but without mutual love, and 40 percent begin with the romantic attachment established and mutual. The remaining 30 percent open with the initial meeting of the lovers, "and these depend almost exclusively on love at first sight, which often occurs in the first frames, without development of either character" (p. 529).

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All humans have a basic need for storytelling, for organizing their experiences into tales of important happenings. Genishi (1994) further asserts that

> Within and through stories, we fashion our relationships with others, joining with them, separating from them, expressing in ways subtle and not so subtle our feelings about the people around us. . . . Stories are an important tool for proclaiming ourselves as cultural beings. . . . We evidence cultural membership both through our ways of crafting stories and in the very content of our tales. . . . Stories have the potential for empowering unheard voices. (pp. 2-4)

In explaining his idea of participation frameworks, Goffman (1981) posited three possible positions a person might take in any communication exchange:

1. The *principal*, whose values and position on an issue are established in the text.

2. The *author*, who creates the content of the communication text.

3. The *animator*, who physically performs the communication act.

In addition, Schiffrin (1990) suggested a fourth position, the idea of *figure*, the character whose image is constructed in the text. Banks (1995) argues that one person could function in all four participation positions simultaneously.

In a *fotonovela* intervention, the principal could be the change agent. That person or organization could provide the basic framework, resources, and creative leadership for a *fotonovela* collaboration project, as well as the health statistics and other pieces of factual information to be included in the narrative. Weaks (1976) warns that "confusion among the producers about the goals of a photonovel will result in confusion among the readers," and he further recommends that a *fotonovela*'s scope be limited to one clearly defined theme because "attempts to combine two unrelated messages . . . will probably result in the dilution of both messages" (p. 7).

In the context of an AIDS prevention intervention, the *fotonovela* author would be both collaborative content creator and member of the target audience. While an author does not play a visible role within the narrative of the *fotonovela* itself, as he or she is not depicted in the dialogue or photos, the readers engage in cognitive involvement with the narrative.

Given that the *fotonovela* combines elements of the comic book and motion picture, it "creates an interpersonal experience between the reader and the image, much as exists between the audience and the film" (Weaks, 1976, p. 1).

A variety of symbols are created by the author and embedded in both the narrative and photos of a *fotonovela* story. According to symbolic interactionism theory, these symbols obtain their meaning from interaction in a social environment, and these meanings may differ according to time and place. Briggs and Wagner (1979) assert that an effective story contains several key elements, including: characterization, dialogue, colorful and descriptive language, transitions, suspense, emotional appeal, clear plot, few digressions, and a conclusion.

An author defines the tone, language, and style of the dialogue script, as well as the issue framing and characterization. The conceptual development of a health promotion *fotonovela* thus should be grounded in the attitudes, knowledge, and beliefs of target population members as reflected in their views, behaviors, and their dramatic writings.

The animator, who physically performs the communication act, could be assumed to be the network of target audience members who read, discuss, and disseminate a *fotonovela* to promote dialogue about a particular health issue. Weaks (1976)

recommends that *fotonovela* producers construct a detailed portrait of the audience that includes: sex, age, ethnicity, educational level, visual literacy, customs and preferences, preconceived ideas about the subject, places where the photonovel is likely to be read, likely methods of distribution, and the number of individuals that can be reached (p. 7).

According to Briggs and Wagner (1979) a person can benefit in many ways from reading and telling stories. They assert that storytelling:

- *Promotes high ideals:* The stories can "satisfy human desires for recognition, love, beauty, and courage . . . (and) fortify persons faced by adverse circumstances and assist them to cling to their ideals."

- *Helps reduce tensions:* "A "transfer" of feeling may occur when the hero or heroine of the story manages to solve her dilemma and thereby provide, vicariously, a tension-relieving solution. It is comforting . . . to discover that story characters also have fears and problems for which solutions may be found. As a result of this association, (the reader) might develop an improved self-concept."

- *Stimulates the imagination:* Imagination can assist a reader in self-reflection. William Wordsworth wrote that "Imagination, which in truth, is but another name for absolute power and clearest insight, amplitude of mind, and reason in her most exalted mood."

- *Entertains:* "Stories can assist to produce social consciousness, group cooperation, and laughter."

- *Assists in the learning process: "Storytelling is an excellent means of enlivening instruction and making it both enjoyable and more meaningful."*

- *Improves communicative ability:* Reading and telling stories can help individuals "recognize worthwhile ideas, organize thoughts and feelings, . . . (and) become more independent, confident, and creative." (Briggs & Wagner, 1979, p. 10-12)

The *figure*, the fourth type of participation framework, is the set of characters in the *fotonovela* narrative. The basic types of characters can be classified according to the ideological basis of the narratives. Flora and Flora (1978) identified three functional categories of Latin American literary *fotonovelas*:

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(1) *Disintegration-integration*, which "serves to break primary ties and integrate workers and peasants into an urban lifestyle" (p. 135). These *fotonovelas* tend to have highly mobile characters, reinforce traditional values and legalistic morality, emphasize trust in fate and love, and highlight incidents central to the lives of the protagonists (p. 142).

(2) *Total-escape*, which "provides a mechanism of escape from real problems" (p. 135). These *fotonovelas* feature a "Cinderella" theme, in which a poor but well-bred girl marries a handsome and older millionaire. This dream is achieved "only when the heroine is willing to let her own happiness be sacrificed for the sake of others" (p. 145).

(3) *Consumer-oriented*, which "encourages consumption of middle-class items" (p. 135). Even though "career is a dirty word" for most of the upper-class heroines in these *fotonovelas*, the stories nevertheless promote the "off-chance that the myth of social mobility actually becomes a reality" for the readers (p. 146).

General media use among African Americans

Longshore (1990) contends that examining the media most likely to reach an intended audience is a key task in the development of prevention messages. An evaluation of mass media use patterns among African Americans could indicate how targeted individuals might react to an AIDS prevention *fotonovela* and whether they would be motivated to read it, based on their other media consumption patterns.

Small regional media outlets play a major role in developing community cohesiveness. Playing the role of social leader, local media unite community members by "providing them with common causes to support and by helping to create a set of personal and public standards, values, and modes of behavior for its audience" (Tripp, 1994, p. 164).

A survey of African Americans by the National Commission on AIDS (1992) showed that 77 percent believed the most popular source of HIV/AIDS information was television, followed by newspapers (45 percent), magazines (40 percent), and radio (30

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percent). However, radio may be best for reaching African American adolescents (Bowen & Michal-Johnson, 1989).

Young African Americans are heavy users of radio and television, possibly because many are isolated from other sources of information. African American children also may feel isolated from the mainstream and turn to radio and television to get a glimpse of the rest of the world (Brown, Childers, Bauman, & Koch, 1990). Among black youth, 53 percent said they read at least one magazine, particularly *Ebony* and *Sports Illustrated,* and most of the youths who read magazines were female. When compared with whites, black youth watch television 15 hours more per week and listen to the radio more than four hours more per week (Klein, Brown, Childers, Oliveri, Porter, & Dykers, 1993).

Although African American youth do not read the newspaper as many times during the week as white youth, they spend more time with the newspaper when they do read it (Cobb & Kenny, 1986). School-based Newspaper in Education programs that began in the late 1970s have contributed to increased readership among African Americans, particularly among young adults and teens (Stone, 1994; Windhauser & Stone, 1981).

Most television and radio use studies typically conclude that African Americans of all ages watch more television than whites and those from other ethnic groups (Perry, 1996). This may be partly due to a lack of newspaper distribution in predominantly African American neighborhoods. Although African Americans in general read the newspaper less often than whites (Stevenson, 1977; Stone, 1978), and those over 35 read

more than those who are younger (Perry, 1996), readership is higher among African Americans age 18 to 34 than among whites the same age (Stone, 1994).

<div align="center">

Cognitive Processes

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The cognitive processes domain of the theoretical model in the present study includes four major components: learning, attitudes, motives, and beliefs. These concepts are grounded in 11 theories in the existing behavioral psychology literature.

The two major cognitive domains of the Theory of Reasoned Action (Fishbein & Ajzen, 1975) include intention and attitude toward the behavior. The Extended Parallel Process Model (Witte, 1996) posits that message processing consists of cognitive appraisal and emotional arousal. The cognitive processes within the Stages of Change model (Prochasta & DiClemente, 1984) include contemplation and preparation. According to the Input/Output Matrix (McGuire, 1989), the response steps that mediate persuasion include exposure to the communication, attending, comprehending/learning, liking/becoming interested, decoding on basis of decision, memory storage of content, and information search and retrieval.

The model shown on the next page, Figure 9, highlights key components of the "cognitive processes" domain of the conceptual framework and introduces a review of literature about these factors and about how individuals, particularly African American youth, tend to process AIDS prevention messages.

**FIGURE 9: Cognitive Processes that Influence
Individual AIDS Preventive Behavior**

Learning Processes

Reading comprehension

Given that many African American youth initiate sexual activity, alcohol or drug use, and other risky behaviors early in life, it is imperative to seek understanding of what messages are most appropriate at various stages of a child's development. For example, prevention messages often require teens to process complex information, which may be difficult for younger children at the concrete operational stage of cognitive development (Boyer & Kegeles, 1991).

Among people of all ages, reading is a complex physical and cognitive activity in which a reader is attracted to symbols, sees them, and interprets them. Researchers theorize that most readers use an interactive model that combines characteristics of both top-down and bottom-up processing. Top-down processing holds that readers use their schemata or prior knowledge to conceptually re-organize and create new meaning from information presented in a text. Bottom-up processing, a lower-level reading skill, builds understanding by identifying features of each word and relating these features to relevant schemata (Zimmerman, 1993).

Reading at school differs from other reading tasks because students expect to be tested or evaluated on what they have gleaned from texts. When reading on the job, workers read only enough to learn how to do a specific task. In developing a *fotonovela* targeting youth, it is assumed that their primary reading goal would be entertainment and that these readers would not be motivated to process complex information because they do not expect to be tested on what they have learned.

Printed materials should be written at an age-appropriate reading level because an individual must be able to comprehend a message before he or she can attend to it. The two types of "attentional processes" within Social Cognitive Theory (Bandura, 1994) are modeled events and observer attributes. The ability to process information, according to the Elaboration Likelihood Model of Persuasion (Petty & Cacioppo, 1981), depends on message comprehensibility, issue familiarity, appropriate schema, distraction, and fear arousal. Further, the nature of cognitive processing depends on the person's initial attitude, the quality of the argument, and whether favorable or unfavorable thoughts predominate. Self-presentation motives and evaluation apprehension are the primary persuasion cues.

In a comparison of pre- and post-test analysis of an AIDS prevention program designed for African American youth, Darlington and Mitchell (1993) found that older youth, aged 15 to 19, did not learn as much or pay as much attention to the content as younger youth, aged 5 to 14.

Social learning

Social learning theory, developed by Bandura (1977), has been used to explain causes of self-directed change in the individual, and how new response tendencies can be learned by modeling an observed behavior. Studies that have applied social learning theory include research about AIDS communication (Reardon, 1989), television violence (Tan, 1986), safety-belt promotion (Geller, 1989), venereal disease education (Greenberg & Gantz, 1989), cardiovascular disease prevention (Flora, Maccoby & Farquhar, 1989), and fatal aggression (Phillips, 1986).

Social learning theory helps explain behavior that considers both environmental forces and internal dispositions to be primary determinants of action. The social learning process has five basic steps: (1) availability of an event to be modeled, (2) attention to the event, (3) retention, (4) performance of the act, and (5) repetition of the act, depending on the degree of reinforcement through external, vicarious, or self-initiated rewards (Bandura, 1994).

Individuals tend to pay attention to events that are distinctive, positive, simple, prevalent, and useful. The degree of learning depends on such variables as attention span, arousal level, perceptual set, and acquired preferences. The Theory of Planned Behavior (Ajzen, 1988) asserts that perceived facilitation encompasses perceived behavioral control and attitude toward the behavior, and these perceptions in turn lead to intent.

Retention involves symbolic coding, cognitive organization, symbolic rehearsal, and enactive rehearsal. An individual's ability to learn and his or her existing cognitive structures determine whether the event is remembered. Whether an individual engages in a behavior depends on how accurately he or she remembers the event, observation of enactments by self or others, and the accuracy of feedback from others or self (Bandura, 1977).

Social learning theory posits that behaviors that are rewarded will be performed, while behaviors that are punished will remain dormant. The extent to which a behavior is rewarded in the individual's everyday social environment largely determines whether the act will be performed. Once social learning has taken place, the individual becomes accustomed to the stimulus or message. Cline (1975) argues that daily exposure to any stimulus for three consecutive weeks is likely to lead to habituation. Individual differences are also important predictors of habituation effects (Ceniti & Malamuth, 1984).

Sexual scripting

Learning about ways that people cognitively represent sexual action sequences can shed light on the communication barriers to practicing safer sex (Edgar, Freimuth, & Hammond, 1988). Several scholars have identified a variety of resistance strategies from which a person could choose. In a study of influence behavior among friends, Manusov (1989) found examples of 28 different resistance tactics, which were grouped into four general categories: direct, challenging, avoidance, and distributive.

McCormick (1979) argued that people use the same tactics to request sex that they use for refusing sexual advances. These tactics include reward, coercion, logic, information, moralizing, and relationship conceptualizing. Both males and females are more likely to rely on direct rather than indirect techniques when resisting sexual

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advances, and a woman's use of nonverbal or other indirect resistance messages frequently results in misunderstanding. Abbey and Melby (1986) found that males tend to view nonverbal cues in a more sexual manner than females. Byers (1988) and Christopher (1988) both argue that many females are not direct enough in communicating resistance and may need to express their desires more definitively.

Direct females typically refuse a male's sexual advances by simply saying "no" without explanation, saying "no" with an accompanying excuse unrelated to the relationship (for example, "I'm expecting company"), or saying "no" with an explanation that the couple was not close enough to engage in the behavior. Most men say they would stop their advances if given one of these responses, and men with liberal views are more willing to comply than males with conservative views (Byers & Wilson, 1985).

Attempts at sexual resistance are carefully planned (McCormick & Jesser, 1983), following a script often learned from one's own peer group (McCormick, Brannigan, & LaPlante, 1984), typically learned by adolescence (McCormick, 1987), and usually governed by sex role stereotypes (Peplau, Rubin, & Hill, 1977). The script allows an individual to "define the situation, name the actors, and plot the behavior" (Gagnon & Simon, 1973, p. 19).

These "sexual scripts" give a person information about how participants in the "play" are expected to act the likely sequence of events, and the scripts are frequently strong. Despite the strength of the script, however, some ambiguity inevitably remains that requires the individual to fill in the gaps; thus, competency with sexual communication may be the result of learning how to gear a generic script to a particular partner and situation (McCormick, 1987). When scripts are tightly defined, changes in a

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person's sexual compliance behavior are often more difficult (Grauerholz & Serpe, 1985).

Peplau (1977) contends that in the standard heterosexual script, males are expected to be the initiator and to get as far as possible, while the female's role is to set the limits on sexual interaction while simultaneously preserving a good reputation.

Grauerholz and Serpe (1985) found that females reported feeling more comfortable in resisting sexual intercourse and less at ease in initiating sex. Females most commonly used persuasive strategies to avoid intercourse with an aroused date (LaPlante, 1980), as well as to initiate intercourse (Perper & Weis, 1987).

Stereotypes about African American heterosexual behaviors include the "hot black mamma" and the "black stud" images (Gleaton & Johnson, 1995). However, when black and white youth are compared, blacks tend to have less stereotypical views of sex roles (Gold & St. Ange, 1974) and more androgynous attitudes (Johnson, 1977) which have been attributed to the sex-role socialization provided by black mothers (Harrison, 1992). In many black families, the first-born, whether boy or girl, is expected to become a nurse-child to a younger child (Young, 1970), and a "mothering" is highly valued, whether the person is male or female (Lewis, 1975).

Motives

Motives are an important category of cognitive factors. The AIDS Risk Reduction Model (Catania, Kegeles, & Coates, 1990) includes a "commitment" component, while the "motivational processes" of Social Cognitive Theory (Bandura, 1994) include external incentives, vicarious incentives, and self-incentives. The Elaboration Likelihood Model of Persuasion (Petty & Cacioppo, 1981) posits that an individual can be motivated

to process information because of issue involvement, relevance commitment, dissonance arousal, and a need for recognition.

Bandura's (1994) social cognitive theory posits that people are knowers, performers, and self-reactors with a capacity for self-direction. An incentive for personal accomplishment is assumed to be the anticipated self-satisfaction gained from fulfilling valued standards – not from the standards themselves but from the fact that others could evaluate the behavior.

While media images of risky behavior can reinforce or establish adolescents' perceptions of their social environment (Klein, 1993), images of risk-reducing behavior may play a role in the development of healthy behaviors by providing behavioral scripts or schemas for these health-related activities (Waczak, 1991).

Bandura (1986) posits that behaviors are learned from observation when they are repeated, simple, vicariously or directly reinforced, and when the individual feels competent in performing them. Social cognitive theory defines the cognitive and motivational processes required for a person to adopt behaviors from observation.

Modeling, a component of Bandura's (1990) social-cognitive theory of self efficacy, encourages a person to imitate the behavior of another respected person. Individuals can be persuaded to engage in a modeled behavior through self-efficacy, involvement, reasoning, fear, or illusion created by positive spin.

Bandura (1990) asserts that "to be most effective, health communications should instill in people the belief that they have the capability to alter their health habits." Devine and Hirt (1989) argue that social modeling theory is appropriate for the development of an AIDS campaign with an interpersonal emphasis. An AIDS message

based on the modeling concept could use a spokesperson who would address a specific audience and fit an appropriate social role while delivering a prevention message.

Social learning by watching others is not merely a process of behavioral mimicry, but involves highly functional and skillful patterns of behavior. In abstract modeling, observers can apply the general rule that governs the specific judgments or actions shown by others. Once they learn the rule, they can use it to judge or generate new instances of behavior that go beyond what they have seen or heard. People acquire standards for categorizing and judging events, linguistic skills of communication, thinking skills on how to gain and use knowledge, and personal standards for regulating one's motivation and conduct (Bandura, 1986).

An observer can learn thinking skills much more easily when models verbalize their thoughts aloud as they engage in problem-solving activities (Meichenbaum, 1984). Bandura identified several ways that individuals can be persuaded to engage in a modeled behavior, including self-efficacy, involvement, reasoning, fear, and illusion (positive spin).

Adolescents tend to assume the best solution to a problem is the most self-centered option, which raises the question of whether unselfish solutions and delayed gratification can be modeled effectively for teens (Johnston, 1983).

Individuals are more motivated to talk to others about a health campaign when some personal satisfaction or reward is associated with the behavior. Dichter (1966) argues that the motivations to talk fall into four categories, each associated with various kinds of involvement:

- *Product involvement*, in which people want to talk about distinctly pleasurable or unpleasurable things because talk serves to relive the pleasure the speaker has obtained and dissipate the excitement aroused by using the product.

- *Self-involvement*, in which the speaker seeks confirmation of the wisdom of his or her decision from peers as a way to reduce dissonance, gain attention, show connoisseurship, to enhance feelings of being first with something, having inside information, suggesting status, spreading the gospel, seeking confirmation of one's own judgment, or asserting superiority.

- *Other involvement*, in which the major motive is the need and intent to help others and share with and enjoy the benefits of the product. Sharing the product can serve to express sentiments of neighborliness, care, friendship, and love.

- *Message involvement*, in which the campaign's message becomes the focus of conversations.

Health beliefs

Among many African Americans, illness is believed to result from disharmony or conflicts in some area of a person's life (Cherry & Newman-Giger, 1991). Beliefs about health vary among African Americans,

> Depending on the degree of adherence to traditional ideas, geographic location, education, scientific orientation, and socioeconomic status. Nevertheless, the Africentric heritage has caused most African Americans to retain a holistic philosophy of health, perceiving mind and body as inseparable and the total person in interaction with the environment. (Lassiter, 1995, p. 8)

After conducting extensive public health studies of low-income blacks, Snow (1983) offered many insights into their health beliefs that could be relevant to the design of an AIDS prevention campaign. Lassiter (1995) summarized Snow's conclusions:

- Some African Americans believe in a twofold classification for the causes of illness, natural or unnatural, with the designation determining where the individual will seek health care. The unnatural causes are due to forces like "worriation" (worry), everyday stress, evil influences, or sorcery. . . . Some African American clients are suspicious of too many blood tests because blood is a substance that can be used in witchcraft.

- Some believe that the failure to worship God through prayer or church attendance could cause a natural illness.

- Low-income African Americans use a large variety of home remedies, traditional healing practices, and over-the-counter drugs. (p. 8-9)

In a study of health protective behaviors practiced by 407 elderly black women living in rural North Carolina, Wilson-Ford (1992) found that prayer was the most common method used for the treatment of illness. The researchers identified the following behaviors among the women, listed in order of priority:

1. Eat nutritious food.

2. Pray / believe in God.

3. Use home remedies and over-the-counter drugs.

4. Sleep / rest.

5. Ignore / forget until condition becomes disabling.

6. Reduce stress.

7. Monitor weight and use of salt and sugar.

8. Avoid alcohol and smoking.

9. Contact health care system. (p. 28)

Several theoretical models have been developed to predict an individual's compliance with health advice. Health beliefs are essential in any persuasion framework for AIDS prevention messages. Perceived threat and perceived efficacy can lead to either defensive or protection motivation, according to the Extended Parallel Process Model (Witte, 1996), and these cognitive processes are mediated by fear. Rogers (1975) Protection Motivation Theory suggests that the more fearful an individual feels, the more likely he or she will perceive a health risk as severe.

The oldest of the health behavior change models is the Health Belief Model, first developed in the early 1950s by a group of social psychologists at the U.S. Public Health Service. The model is a risk-perception framework that explains and predicts why individuals do or do not engage in a wide variety of health-related actions. It "grew out of the widespread failure of people to take actions to prevent asymptomatic diseases" (Conner, 1992, p. 4). The model asserts that perceived susceptibility, seriousness, and threat predict an individual's readiness to undertake a recommended compliance behavior. These factors are mediated by concern or salience about health matters in general, willingness to seek and accept health advice, intention to comply, and positive health activities already a part of the person's life.

The Health Belief Model has been used to predict individual compliance with a variety of health behavior recommendations, including dental checkups, immunizations, cessation of smoking, and condom use to prevent HIV infection (Catania, Kegeles & Coates, 1990; Emmons, 1986; McKusick, Horstman & Coates, 1985). Most studies testing Becker's (1974) Health Belief Model have involved behaviors that are less life-

threatening and involve less complex responses than those arising in the case of AIDS (Montgomery, Joseph, Becker, Ostrow, Kessler, & Kirscht, 1989).

Becker's original model includes the following belief dimensions:

- *Perceived susceptibility:* feelings of personal vulnerability to a condition and one's perception of the risk of contracting a condition.

- *Perceived severity:* feelings about the seriousness of contracting an illness, including evaluations of medical or clinical consequences (i.e., death, disability, or pain) and possible social consequences (i.e., effects of the condition on work, family life, and social relations).

- *Perceived benefits:* beliefs regarding the effectiveness of actions available in reducing the disease threat.

- *Perceived barriers:* psychological constraints such as perceptions that a prescribed behavior may be too expensive, dangerous, unpleasant, difficult, inconvenient, or time-consuming.

In a meta-analysis of Health Belief Model studies, Janz and Becker (1984) found that barriers are the most significant predictors of health behavior, followed by benefits, susceptibility, and severity. Many other health promotion studies have supported this conclusion. For example, in studying a breast self-examination (BSE) intervention for nurses, Agars and McMurray (1993) found that perceived barriers at pre-test and perceived susceptibility at follow-up were predictive of BSE practice. A reminder to practice BSE was significantly associated with an effective BSE technique.

In 1975, Becker and Maiman reformulated the Health Belief Model by adding two belief variables to Becker's (1974) model:

- *Health-related motivations*, including salience of health matters in general, willingness to seek and accept medical direction, intention to comply, and positive health activities.

- *Value of illness threat reduction*, including an individual's estimate of the extent of possible interferences with social rules.

Many AIDS prevention strategies incorporate elements of the Health Belief Model, including perceived vulnerability to AIDS, efficacy to control exposure to AIDS, and proximal threat of AIDS. In a study of 909 homosexuals in Chicago, AIDS knowledge, perceived susceptibility, perceived efficacy of preventive behavior, barriers to action and perceived social norms predicted HIV-preventive practices (Emmons, Joseph, Kessler, Wortman, Montgomery & Ostrow, 1986). However, the behavior change variance explained by these variables was modest, ranging from 7 to 12 percent for the five measures. Aiken, West, Woodward and Reno (1994) found that Health Belief Model constructs accounted for 16 percent of compliance with mammography screening recommendations among white, middle-class women 35 and older, while physician input accounted for 25 percent of the compliance. A possible reason that the Health Belief Model does not robustly explain AIDS preventive behavior is that it fails to account for peer-group influence (Freimuth, 1992).

Perceived risk

Providing information and reasons for changing behavior is necessary but rarely sufficient to cause people to change risky health behaviors. AIDS knowledge alone has been repeatedly shown to be an insufficient precondition of behavior change. However, the responses to knowledge questions indicated that they have received both accurate and

inaccurate information about the transmission of HIV. Therefore, an information campaign about AIDS transmission is needed as a precursor to effective behavior-change messages.

Attitudes

Personal relevance: Perceptions of the risk of contracting AIDS from unsafe sex may not affect a person's behavior unless the risk is personalized (Edgar, Friemuth, & Hammond, 1988). The extent that people believe they are personally at risk of becoming HIV infected is related to their risky behavior.

A related factor linked to risky behavior is optimistic bias, the belief that one's own risk is less than the risk faced by others, particularly others who are perceived as more vulnerable (Weinstein, 1989). Similarly, Cline and Freeman (1988) found that college students perceive their partners as safer if the partners are of similar socioeconomic status. Optimism is greatest for risks with which individuals have little personal experience, and personal experience is a powerful stimulus to action. Since personal experience is much more vivid than statistical information about risks, direct experience with the consequences of AIDS would reduce a person's optimism about his or her invulnerability to the disease (Weinstein, 1989).

Attitudes about AIDS among African Americans: Greenwald (1989) defines an attitude as a human evaluative reaction about an object. Concerning attitudes about AIDS, Overby and Kegeles (1994) found that 41 percent of predominantly black, sexually active female teens reported having personally known someone with AIDS. About 48 percent were very worried about getting AIDS, while 56 percent were very worried about someone they knew getting AIDS. Nearly three-quarters estimated their chance of getting AIDS to be very low or nonexistent, a belief caused by an attitude that the ability to choose partners carefully is more important than the cumulative effect of past relationships.

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Three-quarters of the teens who had a regular boyfriend reported little or no worry about acquiring AIDS from him, and the same number agreed that if "guys know you are taking the pill, they don't want to bother with a condom." About a quarter felt they had little control over whether a condom was used during the last time they had sex.

Pro-social attitudes: Because research has not been published about the attitudinal effects of *fotonovelas* compared with other media, research about pro-social attitudes towards television programming may be useful in illuminating the probable effects of narrative modeling in *fotonovelas*. The *fotonovela* is similar to television programming in that it offers an illustrated narrative format that simulates the frame-by-frame drama of television.

Although many messages about behavioral skills are not amenable to dramatic presentation on television, the narrative format of television programming has been shown to promote pro-social behaviors among older children because they can comprehend more complex messages (Johnston & Ettema, 1982). In contrast with pro-social content, the protagonists depicted in most other television programs seldom suffer adverse consequences of their behaviors, despite their grossly distorted experience with crime, violence, or illness (Brown & Hendee, 1989; Strasburger, 1990).

Stein and Friedrich (1972) found that viewing pro-social television content led to increased pro-social behavior exclusively in lower socioeconomic status children. When these subjects were trained through role-playing to be helpful to friends, those who had viewed pro-social television were more helpful. Television appeared to predispose them to pro-social behavior by providing a model or schema.

Lovelace and Huston (1983) identified three modeling strategies for conveying pro-social messages: model only the pro-social behavior to be promoted, present models who encounter

difficulties when exhibiting pro-social behavior, and create and resolve the difficulties encountered by the pro-social model.

Johnston and Ettema (1982) reported that overt messages in a pro-social television program are usually not recalled because the messages tend to "turn off" the audience. The extent to which a behavior is rewarded in the individual's everyday social environment largely determines whether the act will be performed. The researchers also developed a specific formula for effectively promoting pro-social behaviors that includes standardized plot in which characters engage in non-stereotypical behaviors, encounter difficulties in doing so, overcome difficulties by mastering non-stereotypical behavior, and in the end are rewarded for doing so.

Seeing people react emotionally activates emotion-arousing thoughts and imagery in observers, and these observers can acquire lasting reactions, attitudes, and behavioral tendencies toward persons, places, or things that have been associated with vicarious emotional experiences. They learn to like the things that gratified models, fear what frightened them, and learn to exercise control over the things that are feared (Bandura, 1994).

Normative Processes

The Normative Processes domain of the theoretical framework in the present study includes concepts borrowed from six different existing social psychology theories and behavior change models. The "social influences" domain of the AIDS Risk Reduction Model (Catania, Kegeles, & Coates, 1990) consists of social support and norms, and these factors are assumed to affect risk behavior at every stage of the behavior change process.

The Stages of Change model (Prochasta & DiClemente, 1984) posits that social behaviors influence an individual's contemplation about a recommended behavior, and the

person then will prepare to take compliant action as a result of social reinforcement of the behavior.

The Theory of Planned Behavior (Ajzen, 1988) asserts that normative beliefs influence subjective norms. Subjective norms, in turn, influence an individual's intention to comply with a recommendation, according to the Theory of Reasoned Action (Fishbein & Ajzen, 1975). Reflexively, the extent that subjective norms influence intention depends upon the relative importance of normative considerations. The Theory of Reasoned Action defines normative considerations as a person's beliefs that specific referents (individuals or groups) think he or she should or should not perform a recommended behavior. These beliefs are mediated by the person's motivation to comply with the referents.

The Persuasive Health Messages Framework (Witte, 1995) further clarified this definition by including approval/disapproval of salient referents, metaperceptions of referents' view of the individual's HIV risk, and metaperceptions of referents' beliefs about what happens to people when they are infected with the virus. Given that a cultural custom is a type of norm, Witte's framework also asserts that customs related to sexual discussion are important cues to address in a persuasive message.

The "modifying factors" that mediate cost-benefit analysis, perceived threat, susceptibility, and severity, as posited by the Health Belief Model (Becker, 1974), include source of advice and social pressure. Interpersonal interaction with a health advice source, such as a doctor, also can mediate the decision-making process. Length and depth, as well as mutuality of expectation, are dimensions of this interaction.

The model shown on the next page, Figure 10, highlights key components of the "normative processes" domain of the conceptual framework and introduces a review of

literature about these factors and about how individuals, particularly African American youth, tend to respond to AIDS prevention messages in various social contexts.
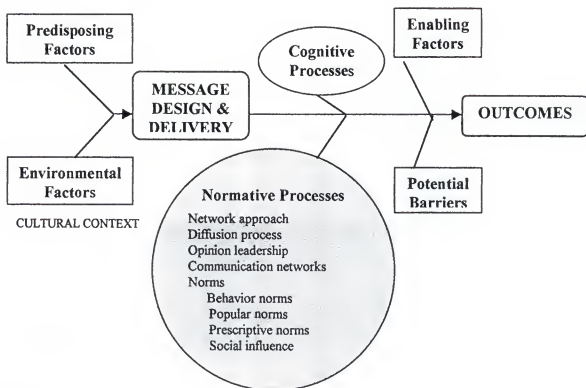
FIGURE 10: Normative Processes that Influence
Individual AIDS Preventive Behavior

The Network Approach

Marketing research has gradually moved from treating buyers and sellers as isolated actors toward focusing upon dyadic exchange (Bagozzi, 1978).

The network approach also has been useful in constructing mass media messages about AIDS prevention. Given that a target audience should not always be treated as an aggregate of separate individuals, several successful campaigns have aimed health messages

at friends and family to prevent drunken driving and hypertension among men (Rogers & Kincaid, 1980).

Fisher and Misovich (1989) found that individuals involved in a social network in which AIDS prevention behavior was a value consistent with the network's belief system demonstrated more AIDS prevention behavior, greater perceived knowledge about AIDS, greater actual knowledge about AIDS, increased belief in the efficacy of preventive behaviors, and higher levels of intended AIDS prevention behavior.

The World Health Organization promotes an "ecologic" view of health promotion by defining it as "a mediating strategy between people and their environments, synthesizing personal choice and social responsibility in health" (WHO, 1986).

Diffusion strategies may be logically developed from such an ecologic perspective, as seen in many of the best known community-based health promotion efforts such as the North Karelia Project in Finland (Puska, 1985), the Minnesota Heart Health Program (Carlaw, 1984), and the Stanford Three Community Study (Maccoby, 1977).

Given that these applications are macro-level and broad-based, with communities and organizations as the primary targets for interventions rather than individuals, the strategies emphasize linkages, mediation, and coordination among systems and organizations (Portnoy, Anderson & Eriksen, 1989).

In a study of community linkages in East Harlem, Indyk and Belville (1995) found that information exchanges, resource sharing, continuing education for health

care providers, and service coordination must be established between and among community organizations and the medical community in order to effectively prevent and treat HIV/AIDS.

The diffusion process

Diffusion of innovations theory can serve as a foundation for AIDS prevention strategies through the development of new community norms.

Freimuth (1992) noted that the content of AIDS campaign messages in the United States has expanded the boundaries of community acceptability. For example, public discussions about HIV and AIDS has moved from the use of euphemisms such as "body fluids" to more explicit language such as the words "blood," "vaginal secretions," and "semen."

Ross and Carson (1988) found that many people frequently seek the advice of friends about the steps needed to reduce risk for AIDS. The "Not Me, Not Now" pregnancy prevention campaign for minority youth trains teens to deliver an abstinence message to their peers in the community (Doyle, 1997).

The design of the Mpowerment Project in San Francisco included a process in which young gay men encourage each other about the need to practice safer sex so that safer sex becomes the mutually accepted norm (CAPS, 1996). Peer support has been a major predictor of risk reduction among gay men, while lack of peer support tends to predict lack of success in recommended behavior change. Further, the beliefs that one's friends already have made precautionary changes and that these changes will be well accepted predict compliance with AIDS risk reduction recommendations (Kelly, 1990;

Kelly, 1991). Theoretical models of AIDS prevention and intervention recommentations developed for homosexual male populations, such as the Mpowerment Project, may be generalizable to African American adolescents' sexual behavior (Reitman, 1996).

According to Rogers (1995), diffusion of innovations is the process of communicating about new ideas through channels over time among the members of a particular social system. An innovation is an idea, practice, or object perceived as new by an individual. Rather than adopting a new idea on the basis of "obvious" benefit, users are assumed to receive and implement the idea within an appropriate cultural context. Thus, an idea is spread more quickly when it is compatible with the norms and values of the social system. The more homogenous the social system, the faster the diffusion rate and the higher the maximum penetration.

Diffusion of innovations theory is used to explain how new ideas spread from their sources to potential receivers and thus create social change, to help close the gap between what is known and what is effectively put to use, to determine the factors affecting the adoption of innovations, and to predict why very few innovations actually spread, while most are forgotten.

Bandura's (1994) social cognitive theory posits three processes of the social diffusion of new behavior patterns: acquisition of knowledge about innovative behaviors, adoption of these behaviors in practice, and social networks through which they spread and are supported. Symbolic modeling, such as the case in which behaviors are promoted by the mass media, usually functions as the principal conveyer of innovations to widely dispersed areas.

Goals of diffusion research include the assessment of relative risk or perceived risk of innovation adoption for the receivers, bringing about overt behavioral change (adoption or rejection of new ideas), creating awareness and knowledge of a new idea through use of mass media channels, changing attitudes toward innovations through interpersonal channels, and shortening the time lag between the introduction of a new idea and its widespread adoption.

Given that social change can occur at both individual and societal levels, sociologists generally consider change at the individual level to be the result of diffusion, adoption, modernization, acculturation, learning, or socialization. Change at the societal level is assumed to involve such processes as development, specialization, integration, and adaptation.

Rogers and Shoemaker (1971) define social change as "the process by which alteration occurs in the structure and function of a social system." Social change, they argue, occurs when the structure or function of a social system is altered. It occurs either when people invent a new idea that then spreads within the system, called *immanent change*, or when external sources introduce a new idea, called *contact change*.

Depending on whether the recognition of the need for change is internal or external, contact change can be selective or directed. Selective contact change occurs when people are exposed to external influences and adopt or reject a new idea from that source on the basis of their needs. Exposure is spontaneous or accidental, and the receivers are left to choose, interpret, and adopt or reject the new idea. When social change is directed or planned, outsiders intentionally seek to introduce new ideas in order

to achieve goals they have defined. In response to a planned diffusion, individuals typically are persuaded, reject the idea, or offer a customary response.

Rogers and Shoemaker propose three sequential steps of social change: *invention*, a process by which new ideas are created and developed, *diffusion*, a process by which new ideas are communicated to the members of a social system, and *consequences*, the changes that occur within a social system as a result of the adoption or rejection of the new idea. Triandis (1972) argues that from a social psychological perspective, social change involves a new set of social relationships and social behaviors that is more likely to lead to rewards.

Lippitt (1973) defines *transmitted* social change as evolutionary change that occurs without deliberate guidance, whereas *transformed* or *planned* social change occurs when individuals, groups, or organizations change themselves or others through conscious actions or decisions. Health promotion programs are typically instances of planned social change, designed to facilitate individual changes in health-related attitudes and behaviors.

The function of an innovation is how the new idea contributes to a community's way of life, and the meaning of an innovation is the subjective perception of the innovation by the social system members. Rogers and Shoemaker (1971) argue that the consequences of an innovation can be dysfunctional if the direct or indirect effects are undesirable, and can be manifest or latent, depending on whether or not the changes are recognized and intended by the social system members.

Byrnes (1966) argues that people may resist adoption of an innovation for many reasons: fear of the consequences of change, traditional orientations, lack of knowledge,

lack of resources, failure to look ahead, satisfaction with existing practices, or the belief that nothing will be gained from change. Byrnes emphasizes that a target audience must be approached in language they understand, in terms that are relevant to their experiences and desires, and by people they trust and respect.

Kolbe and Iverson (1981) argue that effective planned social change depends on the desirability, perceived promise and feasibility of an innovation, its possible positive and negative consequences, and the resources, means, constraints and other environmental factors that affect its implementation.

Rogers (1995) proposes five key characteristics of innovations:

- *Relative advantage*, the unique benefits provided by an innovation and the degree to which an innovation is perceived as better than the idea it supersedes, which may be measured in economic terms, usefulness, payoff time, social prestige factors, convenience, or satisfaction.

- *Comparability*, the degree to which an innovation is perceived as being consistent with the existing values, past experiences, and needs of the receivers. An idea that is incompatible with values or norms will not be adopted as rapidly as one that is compatible. Zaltman and Duncan (1977) referred to this concept as *compatibility*, and further specified that it reflects the degree to which an innovation is congruent with the technical, psychological, sociological, and cultural attributes of the situation in which it is to be used.

- *Complexity*, the degree to which an innovation is perceived as difficult to understand and use. Zaltman and Duncan (1977) referred to this concept as

communicability, and additionally specified that it includes the ease with which information about an innovation can be disseminated.

- *Trialability*, the degree to which an innovation may be experimented with on a limited basis or "installment plan." This dimension also refers to the ease with which an innovation may be discontinued and the permanent consequences of having tried the innovation. Zaltman and Duncan (1977) refer to this concept as *divisibility*.

- *Observability*, which is the degree to which the results of an innovation are visible to others.

In expanding Rogers' conceptual framework, Zaltman and Duncan (1977) proposed five additional dimensions of an innovation that can predict its potential for diffusion:

- *Impact on social relations*, including its positive influence and ability to facilitate relations.

- *Time* required to introduce or implement an innovation.

- *Risk and uncertainty*, including both personal and institutional risk inherent to introducing the innovation and uncertainty about its consequences.

- *Commitment* required to adopt and implement the innovation, usually associated with the magnitude of the innovation's impact.

- *Capacity for successive modification*, which prevents the innovation from becoming dated. Dube (1958) pointed out that an innovation is rarely accepted in the form in which it is presented to the community because a process of screening occurs as it passes from one type of "teacher" to another.

Rogers (1995) suggests a sequential, linear process: After an individual gains knowledge about an innovation, another person who is not yet aware of the new idea learns about the innovation from the first person through some communication channel connecting the two individuals. After a person gains awareness about a new idea, this exposure sparks interest in gaining further knowledge about the innovation. The person then begins to evaluate the idea and forms a general favorable or unfavorable attitude toward the innovation. Finally, the person initiates a small-scale trial of the innovation which leads to its adoption or rejection.

Rogers posits five stages of adoption: knowledge, persuasion, decision, implementation, and confirmation. The success of the last four stages depends on the extent that individuals interact interpersonally within a network.

1. *Knowledge* occurs when a person or decision-making unit learns of an innovation's existence and gains some understanding of how it works. During this stage, a person "mainly seeks information that reduces uncertainty about the cause-effect relationships involved in the innovation's capacity to solve an individual's problem" (Rogers, 1995, p. 21), and mass media channels can effectively transmit this kind of information.

2. *Persuasion* involves the formation of favorable or unfavorable attitudes toward an innovation. A person tends to become a decision-maker and active information seeker through psychological involvement with the innovation and through evaluation of possible consequences. In a survey of Swedish midwives' awareness, attitudes, and use of selected research findings, Berggren (1996) found

that the midwives were in the persuasion stage as indicated by their desire to use research when the findings recommend better care for mothers and babies. As shown by this study, an individual in the persuasion stage tends to network with peers or near-peers to determine an innovation's advantages and disadvantages in his or her own situation.

3. During the *decision* stage, people become involved in interpersonal activities leading them to choose between adopting or not adopting the innovation. Rogers posits three types of decisions: a decision independent of decisions made by others; a collective decision, made by members of a social system through consensus; or a decision based on an authority forced upon individuals by someone in a superordinate power position.

4. The fourth stage involves *implementing*, or using, the innovation. Byrnes (1966) found five principal reasons Philippine farmers adopted new practices: seen and proven effectiveness, novelty of the practice, ease of doing the practice, availability of needed resources, influence of neighbors and friends, influence of extension workers, and the compatibility of the practice with the farmers' needs and goals. Rogers noted that implementation often leads to re-invention of an innovation.

5. The final stage is *confirmation*, in which people seek interpersonal reinforcement of their decision to adopt or not adopt the innovation. If people are exposed to conflicting messages, they may reverse their decision. Havlicek (1980) found four phenomena associated with the likelihood of maintenance, or continuance of an innovation: involvement of community members in planning, training, and

development of materials, assistance to implementers, cooperation, and communications about what the innovation was accomplishing.

In a survey of knowledge, awareness, and adoption of AIDS curricula among Dutch secondary school teachers, Paulussen (1995) found that knowledge acquisition was largely dependent on diffusion networks within schools, while transition from awareness to adoption appeared to be mediated by perceived instrumentality, subjective norms, perceived colleague behavior, and teachers' sexual morality.

Opinion leadership

Rogers (1995) notes that interpersonal channels involving face-to-face exchange are more effective than mass media channels in persuading an individual to accept a new idea, especially if the interpersonal channel links two or more people who are homophilous.

Rogers contends that an innovation is often initiated by a relatively small segment of opinion leaders in the population. Others are influenced after an innovation is visibly modeled and accepted by natural opinion leaders. People are most likely to adopt new behaviors based on favorable evaluations of the innovation conveyed to them by similar, respected others. Community change comes about through a process of informal communication and modeling by peers within their interpersonal networks. DiClemente (1993) notes that the use of peer educators as behavior-change agents is the most underutilized AIDS prevention strategy. Peer educators have been used effectively to prevent and reduce teens' use of substances such as tobacco (Telch, 1990), alcohol (Perry & Grant, 1988), and marijuana (Klepp, 1986). Peer-led interventions in clinics have enhanced HIV knowledge and decreased risk behaviors (Slap, 1991).

Trained peer educators may be more credible, they communicate in a language more likely to be understood, and they can serve as positive role models (DiClemente, 1993). Further, they may be more effective at facilitating acquisition of social skills, such as sexual negotiation or assertiveness (Hein, 1991; Stone & Perry, 1990).

Rogers (1995) posits five basic types of adopters:

1. *Innovators*, the first in their system to adopt a new idea. They are venturesome, active information seekers who have a high degree of mass media exposure, can cope with higher levels of uncertainty about an innovation than others, can understand and apply complex technical knowledge, control substantial financial resources to help absorb possible loss, and whose interpersonal networks extend over a wide area, reaching outside their local system.

2. *Early adopters,* the respected localites or local missionaries, tend to be opinion leaders and role models and are the individuals "to check in with" before using a new idea. This person has higher social status, and continues to earn the esteem of colleagues by maintaining a central position in the communication network, making judicious innovation decisions and conveying subjective evaluations of the innovation to peers.

3. *Early majority,* the person who adopts a new idea just before the average member of the system does, tends to deliberate for some time before adopting, and who interacts frequently with peers, but seldom holds a position of opinion leadership. Early majority adopters make up a third of the members of a system and provide interconnectedness in the system's interpersonal networks.

4. *Late majority,* another third of the members of a system who skeptically and
   cautiously adopt new ideas just after the average person does, because of
   increasing peer pressure. Because of their relatively scarce resources, they will
   not feel safe to adopt until most uncertainty has been removed. An exception to
   this pattern was discovered by Cancian (1981), who found that individuals with
   low or middle socioeconomic status tend to be more innovative than high-middle
   SES individuals because they stand to gain more and lose less.

5. *Laggards,* the last in a social system to adopt an innovation, possess almost no
   opinion leadership and tend to cling to tradition. They tend to be suspicious of
   innovations and change agents, and their resistance often results from a
   precarious economic situation.

Rogers (1995) defines opinion leadership as "the degree to which an individual is
able to influence other individuals' attitudes or overt behavior informally in a desired
way with relative frequency" (p. 27). Opinion leadership is not a function of formal
position or status, but is earned and maintained by a person's technical competence,
social accessibility, and conformity to a system's norms. The most innovative member of
a system usually is not considered an opinion leader because he or she is often perceived
as deviant and thus has lower credibility with the average members.

Katz and Lazarsfeld (1955) define opinion leadership as an "almost invisible,
certainly inconspicuous form of leadership at the person-to-person level of ordinary,
intimate, informal, everyday contact" (p. 138). Deutschmann and Danielson (1960)
contend that opinion leadership frequently involves both relay and reinforcement
functions. Rogers (1995) notes that opinion leaders can lose respect if they deviate too

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far from the existing norms of a system or if they are perceived as too much like professional change agents. This one reason that peer educators tend to be more effective in changing social norms than outside change agents.

Communication networks

Rogers (1995) defines a communication network as "interconnected individuals who are linked by patterned flows of information" (p. 27). These networks of relationships include occupational colleagues, organizational members, kinships, and friendships, and these social clusters range from loosely knit to densely interconnected. In coining his phrase, "intersection of social circles," Simmel (1964) indicated that each individual is unique in that his or her pattern of group affiliations is never exactly the same as that of any other individual.

Fischer (1977) contends that network links represent potential influences on individual behavior, as well as individual influence upon the larger system. These scholars argue that

> Society affects us largely through tugs on strands of our networks – shaping our attitudes, providing opportunities, making demands on us, and so forth. And it is by tugging at those same strands that we make our individual impacts on society – influencing other people's opinions, obtaining favors from "insiders," forming action groups. (p. viii)

Granovetter (1983) found that innovations are more extensively diffused within cohesive groups through weak but multiple social ties. Deutschmann (1962) found that horizontal (peer) conversation is more common than vertical conversation, and face-to-face local messages flow more frequently within groups than between groups.

In investigating the role of friendship cliques on teen drinking behavior, Alexander (1964) found that most of a clique's members were either all drinkers or all

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teetotalers. In the rare case of a non-drinking member of a drinking clique, or vice versa, the person was less connected sociometically than were the others.

Given that no single social network in a community serves all purposes, different innovations engage different networks (Bandura, 1994). In the African American community, for example, abstinence behaviors can be more effectively diffused within the church and within extended family networks and neighborhoods, while condom use practices can be diffused through other organizations within the African American community, such as non-religious youth groups and schools.

Deutsch (1968) argues that "learning nets and societies do not grow best by simplifying or rigidly supporting their parts or members, but rather with the complexity and freedom of these members, so long as they succeed in maintaining or increasing mutual communication" (p. 399). Similarly, Rogers and Kincaid (1980) argue that communication in real-life, natural settings can be understood better "if it is not broken up into a sequence of source-message-channel-receiver acts, but rather examined as complete cycles of communication in which two or more participants mutually share information with one another in order to achieve some common purpose, like mutual understanding and/or collective action" (p. 31).

Rogers and Kincaid's (1980) convergence model of communication, based on a cybernetic explanation of human behavior from a systems perspective, is holistic, focuses on links rather than individuals, and concentrates on the relationships between parts and on interactions of a system with its environment. This model is contrasted with the dominant psychological paradigm in communication research, which focuses on the

individual as the unit of analysis and defines social problems in terms of individual blame rather than system blame.

Rogers and Kincaid argue that when information is shared by two or more individuals, information processing may lead to collective action, as the result of mutual understanding and mutual agreement. Four combinations are possible: mutual understanding with agreement, mutual understanding with disagreement, mutual misunderstanding with agreement, or mutual misunderstanding with disagreement.

The Bass (1969) forecasting model of marketing posits that potential adopters of an innovation are influenced by a combination of mass media and interpersonal word-of-mouth channels. The two-step flow theory of communication, proposed by Lazarsfeld, Berelson, and Gaudet (1948), was developed through a study of voter decision making in the 1940 presidential campaign. They contended that "ideas often flow from radio and print to the opinion leaders and from them to the less active sections of the population." They found that mass media had less direct influence than other people and that these opinion leaders were identified as those who tried to convince others of their own opinions or who were sought out by others for their opinions.

Katz (1957) emphasized that a two-step flow depends on interpersonal relations functioning as communication networks and as sources of social pressure or support. Greenberg (1963) noted that interpersonal channels are used in two-step diffusion primarily for reinforcing existing opinions, rather than for creating or converting attitudes.

Community AIDS prevention networks

The study of communication networks can be useful in the development of community-based AIDS prevention campaigns. Communities act as agents of the dominant culture and as "systems of exchange and influence relationships" to "transmit values and norms that symbolically circumscribe some behavioral choices and encourage others" (Finnegan, Bracht & Viswanath, 1989, p. 56).

Eisenstadt and Shachar (1986) argue that community-based campaigns should be based on the rationale that social and cultural influences are important factors in learning and adopting behavior patterns and that these influences are experienced by individuals through social aggregates and networks that make up communities.

When a community is mobilized to act as a change agent, it lends legitimacy to norms for desirable behavior and makes the social and physical environment more conducive for individuals to act upon recommendations. This mobilization is accomplished through engaging networks of public and private organizations and special interest groups to channel their resources – time, money, personnel, goods, and services – in coordinated activity in a broad range of interpersonal, group, and mass communication strategies (Crosby, Kelly, & Schaefer, 1986). Warren (1963) and Eisenstadt and Shachar (1986) proposed six key concepts in the development of community-based campaign strategies:

- Complexity – the size and specialization of functions.
- Linkage and relationships – the interaction of formal organizations.
- Power and influence – control over resources, coordination, centralization or dispersion.
- Dependence-autonomy and formality of various social relationships

- Community identity
- Social integration or cohesion

Behavior norms

Rogers (1995) defines norms as

The established behavior patterns for members of a social system . . . (that) define a range of tolerable behavior and serve as a guide or standard for the members' behavior. . . . (and) tell an individual what behavior is expected (p. 26).

Norms can operate at the level of a nation, a religious community, an organization, or a local system like a neighborhood. The use of norms to promote or inhibit individual action has long been considered a powerful weapon of social control, often as powerful as laws (Noelle-Neumann, 1974). Cialdini (1989) asserts that individuals tend to act according to the dictates of the type of norm that is currently focal, even when other types of norms might dictate contrary conduct.

The more compatible an innovation is with prevailing social norms and value systems, the greater its adoptability (Rogers & Shoemaker, 1971). HIV prevention programs that change community norms are essential for impact effectiveness (Gorman & Mallon, 1989). Impact effectiveness is a function of the number of people impacted in a given time period.

Youth who have bonded with societal norms and standards are less likely to engage in risky behaviors. Those who are alienated from the dominant values and norms of their family, school, and community tend to exhibit low religiosity, rebelliousness, high tolerance of deviance, and a strong need for independence. Prevention efforts targeting these youth should provide opportunities, skills, and rewards for positive social involvement so they will have a stake in society and feel connected to it (Hawkins, 1990).

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Another strategy for reinforcing social norms to prevent harmful behavior is inoculation, in which bolstering existing resistance attitudes among younger adolescents renders them less vulnerable to the onset of sexual intercourse and subsequent slippage caused by experimentation and growing tolerance toward sex (Bernstein & McAlister, 1976).

Development of an AIDS prevention strategy in the black church could consider cultural norms, belief systems, communication style, views of personal control, existing and potential social networks, and the role of social influence. An intervention strategy could help members of a social network gradually redefine the norms of social decorum until increased openness in discussing AIDS issues can be initiated on an interpersonal level.

Macneil (1980) found significant differences in the extent to which norms predict individual versus interpersonal or organizational behaviors. While the norms that prompt non-relational behaviors tend to revolve around a person's pursuit of individual goals, relational behaviors are based on reciprocity and mutual benefits for the good of the relationship or shared goals. Relational norms theory suggests that members of a religious community could work together toward a mutually beneficial goal, educating others about AIDS risk.

The Extended Behavioral Intention Model developed by Fishbein (1967) proposes that behavioral intentions can be based on a person's own attitude toward a behavior as well as a subjective norm. This may be a relevant concept in developing interventions for the black church, given that many religious teachings encourage introspection as well as meta-perceptions about the morality of behaviors.

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To the extent that a person's value or behavior conflicts with a group-based belief, it will be more strongly challenged through social influence. Conversely, if a value or behavior is consistent with a central belief in a group's assumptive system, it will be supported more vigorously than if it were consistent with a non-central belief (Nadler & Fisher, 1988).

Popular norms

Cialdini and Petty (1981) argue that human behavior is motivated by both prescriptive norms and popular norms. Popular norms involve perceptions of which behaviors are typically or customarily performed.

Bandura's social modeling theory suggests that watching someone else engage in a behavior can focus the viewer on the issue of what other people do in a similar situation. However, Cialdini argues that while a public service announcement might portray an unhealthy behavior with the intent of discouraging individuals from engaging in that unhealthy behavior, an underlying and undercutting message might inadvertently portray the unhealthy behavior as acceptable or consistent with popular norms.

Prescriptive norms

Prescriptive norms involve perceptions of which behaviors are societally sanctioned or customarily approved. Descriptive norms can be either popular or prescriptive, as they motivate individuals to simply "follow the leader" by imitating the leader's actions.

Descriptive norms are used as an information processing shortcut in decision making. For example, many advertisers strive to show that many customers think a product is desirable rather than trying to convince an audience that the product is good

(Venkatesan, 1966). In a series of nine field experiments, Cialdini (1989) found a positive relationship between the number of pieces of litter in the environment and the percentage of people who littered.

Social influence

Social influence has been found to be an important determinant of population risk behaviors in studies of health promotion campaigns about smoking (HHS, 1989), family planning (Rogers, 1973), and AIDS prevention among gay men (McKusick, 1987; Kelly, 1990).

Peer support, a function of social influence, can play an important role in changing or maintaining a person's beliefs or attitudes. Deutsch and Gerard (1955) define two types of social influence, normative and informational, which explain how others can influence an individual's opinions and behaviors. While a normative social influence is an influence to conform with the positive expectations of others, an informational social influence prompts individuals to accept information obtained from others as evidence about reality (p.629).

Internal personal influence is the decision-making effect of mental processes that involve people or groups. Bearden, Netemeyer, and Teel (1989) assert that informational reference group effects occur when low-knowledge individuals seek information from others they consider to be credible experts. Normative influence occurs when a person identifies with a group to enhance his or her self-image and ego or to comply with a group's norms to gain rewards or avoid punishments.

Robertson (1971) found that personal influence is more likely to operate in situations where the decision is riskier, the idea is not easily testable, the individual is more involved in the choice, or the financial or emotional investment is high.

Lessig and Park (1978) define reference groups as actual or imaginary institutions, individuals or groups having significant relevance on a target individual's evaluations, aspirations, or behavior. Reference groups can be used as standards of comparison for self-appraisal, those considered to be informative experts, or those used as a source of norms, standards, and attitudes. A reference group can be a large social grouping, such as ethnic group, social class, or subculture.

Batra, Myers and Aaker (1996) note that an individual does not have to be a member of a reference group for the influence to occur. They note that external influences can lead to personal decision making based on explicit social interactions, such as a situation where two or more people are involved. A person might seek to include friends, family, or neighbors in his or her decision-making process or otherwise refer to the proposed idea in the course of conversations and social interactions.

Rogers (1995) asserts that mass media and other impersonal sources of influence are typically most important during the early stages of awareness and interest, and word-of-mouth and personal influence tend to be most important in the later stages of evaluation, trial, and adoption.

Gatignon and Robertson (1991) found that advertising can have its greatest influence on diffusion when the level of cognitive processing is low, whereas personal influence will be greatest when there is a large amount of cognitive activity. Thus,

personal influence is more important for information seeking and mass media are more important for information giving.

Settle and Alreck (1989) contend that individuals "play out" social roles that are either sought and acquired voluntarily or ascribed to them by society. Most people look to reference groups, either actual or depicted in the media, to learn how to play their roles. When people are uncertain about what to do in a social situation, they turn to others for guidance.

Individuals differ in the extent of their susceptibility to social and group influence (Bearden, Netemeyer, & Teel, 1989). Those who are more easily persuaded by reference group influences tend to be more extroverted, more likely to engage in social interactions, and more affected by the opinions of friends, neighbors, role models, and others. Park and Lessig (1977) found that younger people are more susceptible to reference group influence partially because they tend to have lower knowledge, lower self-confidence in decision making, more social contacts, greater social visibility, and to be undergoing more intense identity-seeking and socialization processes.

Batra, Myers and Aaker (1996) note that advertisers rely heavily on group influence and often try to appeal to a consumer's needs for group identification, belongingness, and adherence to social and community norms. They define word-of-mouth advertising as "a form of personal influence in which information is passed along or diffused through a social system from one person to the next" (p. 346). Television commercials and public service announcements that use "slice-of-life" appeals often show a person demonstrating benefits to another, thus simulating a personal influence process.

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Salient referents

Fishbein and Ajzen's (1975) theory of reasoned action incorporates concepts of beliefs about referents' behavior, attitudes toward people and institutions, intention, personality traits, demographic variables, subjective norms, and personal behavior. The theory is based on the idea that the most immediate determinant of a person's behavior is what the person intends to do. The intention to perform or not perform a particular behavior is a function of the person's attitude toward the behavior and the person's subjective norm – the general perception of whether important others desire the performance or nonperformance of the behavior.

The theory of reasoned action describes how a person processes social influence, positing that a person's attitude is a function of both the weighted evaluation of each belief combined with the weighted strength with which each belief is held. Further, an individual's subjective norm is a function of the normative beliefs that the person ascribes to particular salient others and his or her motivation to comply with these others (O'Keefe, 1990). Although the model assumes that the individual is a rational decision maker, it does emphasize that attitudes and beliefs are largely influenced by culture and lead to specific actions within a cultural context.

The theory of reasoned action can be useful in explaining how people weigh costs and benefits when making AIDS prevention decisions. Aoki (1989) argues that the theory emphasizes changing beliefs about the "direct personal consequences of adopting or ignoring protective behavior" and implies that community norms must be affected first in order to integrate such behavior into the subjective standards of the community as a whole (p.301).

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It also emphasizes that false beliefs, such as the idea that only white gay men get AIDS, must be changed before any significant behavior change can occur. Two important interpersonal components of the theory of reasoned action are the expectations of significant others and the importance of conformity. Taking into account these concepts, rooted in African American culture, would increase the applicability of the theory of reasoned action to AIDS prevention strategies within that community.

Parental influence

In a survey of 751 never-married inner-city black youths and their mothers or caretakers, Jaccard, Dittus, and Gordon (1996) found that adolescent perceptions of maternal disapproval of premarital sex and satisfaction with the mother-child relationship were significantly related to abstinence from adolescent sexual activity and to less-frequent sexual intercourse and more consistent use of contraceptives among sexually active youths. Teens who reported a low level of satisfaction with their mother were more than twice as likely as those highly satisfied with their relationship to be having sexual intercourse. Discussions about birth control were associated with an increased likelihood that teens were sexually active.

A number of other studies also have suggested that parental attitudes toward premarital sexual intercourse may influence the sexual activity and contraceptive behavior of teens. Miller (1986) found that parents who exercise low levels of supervision over the dating activities of their teens are more likely to have teens who engage in sexual risk behavior. Moore, Peterson and Furstenberg (1986) found that parent-teen communication about sex was related to lower levels of adolescent sexual behavior for young women from more traditional families but not for those from less

traditional families. Treboux and Busch-Rossnagel (1990) found that general parental attitudes toward premarital sex were predictive of adolescent premarital sexual attitudes, which were in turn related to adolescent sexual behavior. Scott (1993) found a relationship between sexual activity and the quality of the mother-daughter relationship among African Americans.

Crawford (1993) found that African American mothers who possessed more formal education reported greater levels of parent-child communication, and those who possessed higher levels of self-esteem indicated that they discussed sexual topics with their children more than parents with lower self-esteem.

The Johns Hopkins University Center for Communication Programs conducted a survey-based evaluation study of the Campaign for Our Children teen pregnancy program in Maryland, in which it found that 75 percent of youths said the program helped them talk with their parents about sexuality, family life, dating, and other related issues. The national average for this kind of parent-child communication is 20 percent, according to the Maryland Governor's Council on Adolescent Pregnancy (CFOC, 1997). In a related evaluation study of the "Not Me, Not Now" pregnancy prevention campaign of Monroe County, N.Y., no significant changes were found in the likelihood that a student would talk to their parents about a personal relationship or sex as a result of the campaign, although 37 percent said it was somewhat likely and 20 percent said it was very likely or extremely likely that they would engage in this kind of dialogue.

Jaccard, Dittus, and Gordon (1996) note three key advantages of having parents or other family members educating teens about sex:

1. It permits the presentation of information in a context consistent with parents' values.

2. Parents can tailor the timing and content of information to the specific life circumstances, maturity, and personality of their child.

3. Parents can be sensitive to the entire family context, such as sibling relationships and daily stressors.

Enabling Factors

The Enabling Factors domain of the theoretical framework includes various conditions that can facilitate compliance with an AIDS prevention message. The definitions of these factors and their interaction with other variables in the persuasion process are discussed within each component of the Enabling Factors literature review.

The enabling factors of the Health Belief Model (Becker, 1974) include prior experience with the action or regimen, prior experience with the illness, and perceived benefits. The Persuasive Health Messages Framework (Witte, 1995) additionally suggests that family values be reinforced in an AIDS prevention message.

Diffusion of Innovations theory (Rogers, 1995) asserts that an individual is more likely to be persuaded to adopt a new idea if the person can assess its compatibility with his or her existing situation, its observability and trialability among others, and its relative advantage (as compared with other alternatives).

The Theory of Planned Behavior (Ajzen, 1988) labels enabling factors as "perceived facilitation," and this facilitation leads to perceived behavioral control (self-efficacy) and finally to the intention to change. Similarly, the Theory of Reasoned

Action (Fishbein & Ajzen, 1975) asserts that an individual decides whether to comply with health advice based on beliefs that the behavior will lead to certain outcomes.

Protection Motivation Theory (Rogers, 1975) posits that perceived response efficacy is influenced by a fear appeal. The individual's belief in the efficacy of his or her ability to cope with a threat (self-efficacy) is a cognitive mediating response that can lead to attitude change and the intent to adopt a recommended response. The Extended Parallel Process Model (Witte, 1996) posits that self-efficacy and response efficacy leads to protection motivation if the individual exercises danger control rather than fear control, because danger control leads to adaptive change.

The AIDS Risk Reduction Model (Catania, Kegeles, & Coates, 1990) asserts that the perceived benefits of making changes are a function of perceived response efficacy. The higher the response efficacy, the greater the commitment to change. The ARRM also posits that the acquisition of communication skills enables an individual to enact an AIDS prevention recommendation.

McGuire's (1989) Input/Output Matrix asserts that the response steps needed to mediate persuasion include skill acquisition (learning how to perform the behavior) and social reinforcement of the desired acts. Similarly, the enabling factors within the Social Cognitive Theory framework (Bandura, 1994) include skills, knowledge, outcome expectations, self-efficacy, and personal goals.

The enabling skills posited by the Stages of Change model (Prochasta & DiClemente, 1984) include environmental restructuring, planning, and problem solving. When an individual prepares to act, he or she must set proximal goals in order to adopt a new behavior. Once individuals adopt a new behavior, they must have enough self-

efficacy to overcome setbacks, sufficient skills to prevent relapse, and the intent to monitor their own progress and extend their personal goals.

The model shown on the next page, Figure 11, highlights key components of the "enabling factors" domain of the conceptual framework and introduces a review of literature about the factors that enable individuals, particularly African American youth, to comply with AIDS prevention recommendations.

Self-Efficacy

Behavior change campaigns can facilitate behavior change by improving individuals' self-efficacy, or by removing perceived barriers (Bandura, 1977). Perceived self-efficacy is an individual's judgment about how well he or she can organize and execute a specific cognitive, social, or behavioral skill in a variety of circumstances. For example, a person articulating a self-efficacy belief might say that "I am able to postpone sexual involvement to prevent my getting AIDS."

Self-efficacy can be developed through strategy training, which often is accomplished by encouraging individuals to imitate a respected person. If a person's perceived self-efficacy could be measured, future behavior might be predicted more accurately (Bandura, 1977). Self-efficacy supports change in a variety of behaviors, including the decisions to engage in sexual activity.

Preventive health practices are better promoted by heightening self-efficacy than by elevating fear (Beck & Lund, 1981). Both the preexisting and induced level of perceived self-efficacy influence the likelihood of the adoption and social diffusion of health practices (Maibach, Flora & Nass, 1991).
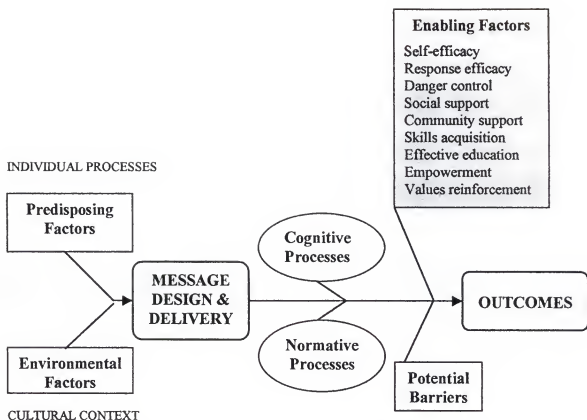
FIGURE 11: Factors that Enable an Individual to Comply with AIDS Prevention Advice

In black culture, validation by peers serves to enhance self-esteem and self-efficacy. While some studies have associated the African American child with low self-esteem, Staples (1988) found that these children are not likely to suffer from low self-esteem because of many supportive influences, including religion, reference groups, group identification, and positive experiences in the extended family. Similarly, Verkuyten (1988) found that most African American adolescents have healthy self-esteem because these youngsters tend to focus more on the perceived judgments of family members and other significant others than on the opinions of society.

Manns (1992) notes several nuances of validation used by both family members and non-relatives within the African American community:

- *Positive defining*, in which a significant other articulates a direct positive definition of the individual, in order to build up the person's sense of importance and worth.

- *Heritage reminding*, in which a significant other advises the individual of his or her racial background, to promote a sense of pride in black roots and the need to appreciate it.

- *Achievement socialization*, in which a significant other establishes or mandates an achievement atmosphere or stipulates specific goals.

- *Teaching,* in which a significant other instructs the individual about skills, strategies, or philosophies. The black elderly often use a "maxim" as a teaching tool in interactions with younger family members (Martin & Martin, 1978).

- *Nurturing,* in which a significant other offers emotional support and love.

Response Efficacy

Response efficacy involves beliefs about the effectiveness of a recommended response in deterring the threat (Witte, 1996). For example, a person articulating a response efficacy belief might say, "Postponing sexual involvement will prevent my getting AIDS."

From the viewpoint of protection motivation theory, response efficacy is a form of coping appraisal that is positively related to the persuasiveness of threat appeals (Kimura, 1997). Witte (1996) found that when individuals believe a health recommendation will really work, they are likely to be motivated to control the danger posed by the health threat if they also believe that they are susceptible to the threat and that the threat is severe. However, even when individuals have high perceived susceptibility and high perceived severity, they are likely to reject a health recommendation if they also have low perceived response

efficacy. This failure to comply often is rooted in defensive avoidance or denial of the threat, which are both forms of fear control.

Most AIDS prevention studies of response efficacy have examined psychosocial correlates of condom use. For example, Roper (1994) found that assertions that minimize the potential efficacy of condoms may be self-fulfilling prophecies because individuals may use condoms less consistently if they do not believe them to be effective.

Some studies have shown a strong connection between self-efficacy and response efficacy, while other studies have not found this link. De Wit (1994) found that individuals who believe they are capable of putting on a condom themselves were less likely to experience condom failure than those who found this difficult. However, Malow (1994) found that response efficacy was not associated with self-efficacy in a survey of heterosexual, cocaine-dependent African American men. Although the men who used condoms (62 percent of the subjects) reported significantly higher levels of self-efficacy, condom use skills, and sexual communication with sexual partners than did those who did not use condoms, the condom users were not more or less likely than the non-users to believe that condoms are effective.

Danger Control

Danger control is a component of the Extended Parallel Process Model, developed by Witte (1996). Danger control involves a cognitive process eliciting protection motivation, and it occurs when individuals believe they can avert a significant and relevant threat through self-protective changes (Witte, 1996). When people are involved in danger control, they think of strategies to avert a threat, and their beliefs,

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attitudes, intentions, and/or behavior change are more likely to comply with relevant health advice. A threat can motivate people to strengthen arguments that underpin their resistance attitudes and thus resist subsequent pressure to engage in risky behavior (Anderson & McGuire, 1965).

Danger control responses are the result of high perceived self-efficacy or high perceived response efficacy, while fear control responses occur when an individual has low perceived efficacy. Danger control thus is more likely to lead to compliance with a health recommendation than fear control, as fear control elicits negative coping responses such as defensive avoidance, denial, derogation of the issue or message, or perceived manipulative intent (Witte, 1996). Fear appeals have been found to be ineffective when perceptions of threat are high and efficacy beliefs are low (Kleinot & Rogers, 1982; Rogers & Mewborn, 1976).

Social Support

Dichter (1966) asserts that a listener must receive some satisfaction or reward from an interaction with a speaker. Therefore, the person who recommends something needs to be interested in the listener and his or her well-being, the speaker's experience with and knowledge must be convincing, and there must be mutual trust between them. This empathy and trust are components of social support, generally defined as the existence and availability of others on whom people can rely and who let them know that they value and care about them (Sarason, Levine, Basham, & Sarason, 1983). Social support facilitates psychological adjustment and well-being in general (House, Landis, & Umberson, 1988) and leads people to feel that there are others they can turn to in times

of need who will provide satisfactory support. Cohen and Wills (1985) assert that social support can serve five functions:

1. Positively contribute to feelings of self-esteem and acceptance by letting individuals know that they are valued, worthy, and accepted, regardless of their problems or deficiencies.

2. Counteract feelings of helplessness, low self-esteem, and other destructive thoughts and thus reduce perceived barriers and enhance perceived self-efficacy. Albrecht and Adelman (1987) identify four kinds of supportive messages that enhance personal control: messages that increase the desirability of achievable goals, and those that emphasize acquisition of problem-solving and communication skills, tangible assistance, and acceptance or assurance.

3. Serve an informational function by helping individuals interpret, comprehend, and cope with a behavior change recommendation in functional ways.

4. Fulfill needs for social companionship and affiliation, and contribute to feelings of "belongingness."

5. Provide individuals with the material resources and services they need to change their behavior.

A form of social support that is essential in the network diffusion of HIV prevention information is advice. Goldsmith and Fitch (1997) note that advice can provide expert opinion on how to solve a problem, another point of view in making a decision, or assistance in laying out options. The authors identify three dilemmas of seeking, receiving, and giving advice: advice may be seen as helpful and caring or as butting in or criticism of the recipient's competence; it may or may not be experienced as honest or supportive; or, seeking or receiving advice may either make the receiver appear less autonomous and competent or it may enact respect and gratitude while the

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recipient reserves the right to make his or her own decision. Further, advice can function to reassure someone by making a problem appear manageable.

AIDS educators can play a role in developing and reinforcing social support and supportive messages. Michal-Johnson and Bowen (1992) suggest that when respect, trust, and empowerment guide their efforts, educators can help individuals gain communication skills that will enable them to change their lifestyles without fear of negative judgment.

Community support for AIDS prevention

At a 1987 national conference about African American health, Reed Tuckson, commissioner of health for the District of Columbia, predicted in a speech that the AIDS epidemic in the black community

> Will give us the opportunity for a fundamental restructuring. . . . The threat that AIDS represents is so severe, so serious, that it will force us to change how we behave as a civilized, or, in this case, an uncivilized society. . . . We will be forced to make changes in our sense of who we are (Quoted in Billingsley, 1992, p.168).

The minority adolescents who are hardest hit with HIV infection and who are hardest to reach are minority teens who drop out of school, run away from home, engage in prostitution, or who are homosexual. The challenge to motivate these teens to change their behaviors rests with community-based organizations that can reach out to teens on the streets, in the housing projects, and in juvenile detention centers (Bowen & Michal-Johnson, 1990).

Oyemade and Brandon-Monye (1990) assert that prevention programs are most successful when their efforts target minority youth and when communities and families provide full support for these efforts. In addressing AIDS and other problems in the black community, Bell and Jenkins (1990) urge development of a community-level

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education and awareness campaign to "increase the black community's awareness of the problem and increase black ownership of it" (p. 148). They recommend that community-based programs strive to enhance racial identity and solidarity, encourage values, a sense of direction, and high self-esteem among black youths, and recruit more privileged blacks to help those in greater danger.

Acquisition of AIDS prevention skills

In a review of school-based AIDS prevention programs, Kirby and DiClemente (1993) found that effective programs have seven common characteristics:

- Use social learning theory, cognitive behavioral theory, or social influence theory as a foundation for program development.

- Maintain a narrow focus on reducing sexual risk-taking behaviors.

- Use active learning methods of instruction.

- Include activities that address social and/or media influences and pressures to have sex.

- Focus on and reinforce clear and appropriate values against unprotected sex (postponing sex, avoiding unprotected intercourse, or avoiding high-risk partners).

- Provide modeling and practice of communication or negotiation skills.

- Tailor programs to be developmentally appropriate and culturally relevant.

Successful non-school-based AIDS interventions targeting African American male teens (Jemmott, Jemmott, & Fong, 1992), minority runaway teens (Rotheram-Borus, Koopman, Haignere, & Davies, 1991) and teenage girls (Slap, Plotkin, Khalid, Michelman, & Forke, 1991) also contain many of the key components of an effective intervention, as identified by Kirby and DiClemente. Schinke (1992), for example, designed and tested an interactive videodisk that included culturally sensitive AIDS

intervention vignettes for African American and Hispanic youth, as well as an accompanying curriculum.

Doyle (1997) notes that the essential components of the "Not Me, Not Now" pregnancy prevention program include a "kids teaching kids" approach, teaching parents and their children communication skills for discussing personal issues and sex, and the promotion of resistance skills that enable teens to handle peer and social pressure.

Empowerment

Much of the sociological research in the past has portrayed African Americans as passive and powerless or as victims of white racism and slum pathologies. However, many recent studies have contradicted these stereotypes by conveying a sense of active involvement and by supporting the view that African Americans are an empowered people who are engaged in struggle, living their lives with dignity, and shaping their own futures (Goings, 1996).

Smith (1996) argues that black empowerment is the product disciplined self-reliance and compassion for the well-being of all African Americans.

Frame and Williams (1996) argue that reconnecting African Americans to their powerful spiritual traditions may be a crucial catalyst for personal empowerment because African American spirituality plays an important role in shaping self-identity and in producing social change. They posit three components of African American spirituality unique to that culture: the prominence of the African American church, the importance of liberation and freedom as Biblical themes, and the centrality of music including indigenous African rhythms, Negro Spirituals, blues, soul, jazz, and rap. Moore (1991) argues that the African-American church always has been a source of empowerment

because it has helped forge an identity for a people removed from their homeland and offers mutual assistance, a center for social change, and a place where shared needs and hopes can be expressed.

Neighbors (1995) argue that the African American tradition of community-based self-help can help individuals reject self-blame, take personal responsibility for their health, and develop collective action. Bolstering self-esteem is a basic empowerment method, given that persons of lower self esteem are less resistant to peer pressure, and higher levels of self-esteem can serve to attenuate or potentiate the effectiveness of AIDS prevention strategies (Botvin, 1982; Flay, 1985). In developing a cancer prevention awareness program targeting black audiences, the National Cancer Institute recommended that messages should emphasize empowerment and self-esteem in order to be effective (OCC, 1983). Similarly, Ford (1996) used an empowerment-centered, church-based approach to educate African American adults about asthma.

Gleaton and Johnson (1995) define empowerment as "a long term process involving the stimulation of awareness and active participation of the concerned parties" (p. iv). In his classic critique of the dominant philosophical paradigm of education, Paulo Freire (1968) points to the dangers of equating teaching with telling, with assuming that students are empty vessels, and of separating learning from action. Freire supports the idea of an empowering process of education that emphasizes the collective action, decision making, and full participation of learners.

Freire views education as a tool for liberation, which takes place when the oppressed see their situation as a reality that they can affect and transform. He uses a "banking" metaphor to describe the traditional process of a teacher "depositing"

knowledge into passive students, which leads to dependence and a fragmented view of reality. By contrast, Freire's "problem posing" approach breaks down the teacher-student dichotomy to establish a situation of equality, dialogue, mutual communication, and praxis, the process of action-reflection-action.

Freire's co-intentional approach called upon educators to promote commitment to change by identifying the levels of individual awareness within a target community:

- *Magic awareness*, in which people are fatalistic because they believe events and forces shaping their lives are myth or magic-related.

- *Naïve awareness*, in which individuals have limited knowledge about what shapes their lives but strive to adapt to the system that controls those conditions.

- *Critical awareness*, in which people examine and question the causes of their problems, observe and reason about them, and attempt to change the system that is creating or reinforcing them.

Freire argues that a "culture circle," a group of learners whose facilitator structures the discussion, can promote critical awareness and reflection about their own reality and the constraints put on their lives. In their studies of health promotion strategies for African Americans and other minorities, Braithwaite and Lythcott (1989) note that Freire's approach shifts the locus of control from experts to participants.

Given that individuals can be easily confused by large volumes of material offered in a multimedia AIDS campaign (Hastings, Eadie & Scott, 1990), and that the term "AIDS prevention" implies the unrealistic goal of no new HIV infections, the principle of harm reduction may offer a more practical and empowering approach to AIDS education (CAPS, 1993).

Also known as "secondary prevention" or "risk minimization," harm reduction philosophically dovetails with the problem-posing education approach by recognizing

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that individuals are the experts about their own behavior, and their ability to function with their behavior must be defined by them. It requires that options be presented in a holistic, non-judgmental, non-coercive way, respectful of individuals' competence to make choices and changes in their lives. The primary goal is to educate individuals to become more conscious of their risky behavior, increase their self-esteem and self-efficacy, and then provide them with tools and resources with which they can reduce their risk (CAPS, 1993).

Reinforcement of religious values

Many studies have shown a link between religiosity and health behavior. While some have shown religiosity to be an intervening barrier to compliance (i.e., homophobia) and a direct predictor of noncompliance (i.e., refusal to use condoms or discuss safer sex), others have shown it to be related to good health, self-care, and well-being.

Among both African American men and women who are 18 and older, organizational religiosity is strongly correlated with life satisfaction and well-being, even when controlling for various socio-demographic variables (Levin, Taylor, & Chatters, 1995). McIntosh and Danigelis (1995) found that formal religious participation decreases negative affect among older black women. When the black church helps protect individuals from the negative effects of various problematic circumstances, this spiritual, emotional, and material support in turn can lower their risk of hypertension and many other health problems (Dressler, 1996).

In studying family planning needs among inner-city homeless women, Shuler (1994) found that 92 percent of the women reported one or more religious practices, such

as praying, attending worship services, or reading religious materials. Nearly half of the women who prayed also used less alcohol and/or street drugs, had fewer perceived worries, and fewer depressive symptoms. Similarly, frequency of church attendance among black men reduces the frequency of smoking and daily drinking (Brown & Gary, 1994). Among minority women, religiosity is a predictor of compliance with the recommendation to use mammography screening (Miller & Champion, 1993).

Religious commitment among adolescents tends to diminish the propensity to engage in sexual intercourse and delay the age for onset of sexual intercourse (Nicholas & Durrheim, 1995; Dunne, 1994). Similarly, Caetano and Hines (1995) found that African American men who are more religious are less likely to engage in unsafe sex.

Numerous churches have implemented health programs (Boario, 1993), many which are African American (Tuggle, 1995) and many which view health as a holistic interplay of body, mind, and spirit (Miskelly, 1995). Nurse ministries, for example, promote the Gospel through health education, health counseling, patient advocacy, referrals, support groups, and volunteer training (Salewski, 1993; Adams, 1993; Newsome, 1994).

Participation in church activities also can expose individuals directly to health advice, information, and resources. African American churches have served as effective settings for the national "Healthy People 2000" initiative that encourages people to consume five or more servings of fruits and vegetables every day (Havas, Heimendinger, Damron, Nicklas, Cowan, Beresford, Sorensen, Buller, Bishop, & Baranowski, 1995). Similarly, in an inner-city, church-based cervical cancer control program for black and Hispanic women, 96 percent of the targeted women in 24 congregations participated in

the education and screening program. The program was based on a social influence model of training of lay health leaders to serve as messengers, recruiters, and organizers (Davis, Bustamante, Brown, Wolde-Tsadik, Savage, Cheng, & Howland, 1994).

In implementing a church-based smoking cessation program for inner-city African Americans, Stillman (1993) built trust by recruiting ministers and lay volunteers to mediate culturally specific interventions and conduct health screenings. African American men who participated in a prostate cancer screening program demonstrated significant improvements in knowledge and self-efficacy after completing a church-based intervention conducted by trained lay educators who previously had been treated for the disease (Boehm, 1995).

The church can provide needed support for those attempting to reduce their risk of getting AIDS. Although AIDS interventions in the black church must be sensitively and carefully crafted, the church can assist in creating a community-level atmosphere that supports AIDS prevention norms and reinforces school-based prevention messages (Coates, 1990; Kelly & Murphy, 1992).

Some black ministers have begun to address AIDS more directly and prominently, preaching messages of compassion and charity toward those who are ill (Goldman, 1989). Despite a theological emphasis upon abstinence in most churches, some facets of African ancestry may offer inroads to a more open discussion of sexuality in a spiritual context that may include safer sex advice, depending upon the theological conservativism of the church. The quest for African American liberation, Goboldte (1995) argues, focuses on Afrocentrism, "the reclamation of African-centered cultural perspectives and ethos" (p. 242). Walker-Alexander, an African American writer, commented that

There is an earthiness to our spirituality and sexuality that comes from our African ancestry. . . . that we expressed in uninhibited movement in dance and song. . . . Sexuality is a strong force in creativity. It works with my spirituality, not apart from it (Quoted in Buckner, 1995, p. 226-227).

The disintegration of community networks often leads to "community meltdown" – increasing crime, intensifying drug abuse, and indiscriminate and frequent sexual activity, particularly among youth. The black church also can assist in "community recrystallization" efforts, which are needed to facilitate AIDS education efforts (Wallace, 1993). Franklin and Norton's (1987) strategic framework for community-based problem solving implies that black churches could take the lead in defining new and continuing problems related to the local AIDS situation, in communicating the urgency of those problems to congregations and to the community, and in prescribing and initiating solutions.

Black churches that engage in community outreach differ in several respects from those that do not (Billingsley, 1992). Churches that are more likely to sponsor outreach programs include those which have larger memberships, been established in the community longer, higher numbers of paid clergy and other staff, higher level of education of the senior minister, ownership of facilities, facilities which are made available for non-religious activities, a senior minister who perceives the role of his church to be serving both members and community, and a senior minister who is active in community activities. Regression analysis shows that the black churches most likely to initiate community health outreach programs are those which have larger congregations and which have a more highly educated minister (Thomas, 1994).

Within its existing value structure, the black church can provide support groups for people living with AIDS who are non-white and non-gay. Some black churches have spent years developing AIDS ministries because the disease has affected members of their congregations (McGhee, 1992). Weitz (1989) notes that HIV positive, heterosexual African American women are far less likely to have networks of fellow sufferers to whom they can turn for advice and information.

The church can provide needed support for those who are directly affected by HIV, including caretakers, orphaned children, and the ill. The congregation can provide tangible and emotional resources for people living with AIDS that other institutions within the community cannot, and it can help people living with AIDS improve their health by providing social support, an environment for prayer and worship, and the inspiration to believe in miracles. Carson (1993) found positive relationships between hardiness of long-term survivors of AIDS and their perceptions of spiritual health and participation in prayer and meditation. Hall (1994) found that people coping with end-stage AIDS maintain hope through involvement in work or vocations, support of family and friends, miracles, and religion.

Potential Barriers

The Potential Barriers domain of the theoretical framework includes factors that can inhibit an individual from adopting a behavior recommended by an AIDS prevention message. The barriers dimension of the AIDS Risk Reduction Model (Catania, Kegeles, & Coates, 1990) includes aversive emotions (i.e., persistent anxiety about being at risk), and aversive emotions are assumed to come into play at the labeling, commitment, and enactment stages of behavioral change. The Extended Parallel Process Model (Witte,

1996) identifies fear and defensive motivation as maladaptive changes in the fear control process.

Diffusion of Innovations theory (Rogers, 1995) identifies perceived complexity as a key factor that can inhibit adoption of a new idea. The perceived barriers domain of the Health Belief Model (Becker, 1974) is part of the cost-benefit analysis assumed to characterize the health behavior change process. The likelihood that a person will comply with a particular health advice message is thus determined by a rational equation: perceived benefits minus perceived barriers.

Barriers to compliance within the Theory of Reasoned Action (Fishbein & Ajzen, 1975) include lack of intention to perform the behavior, negative attitudes toward institutions and toward the behavior itself, lack of motivation to comply with specific referents who think the individual should perform the behavior, and conversely, the belief that specific referents think the individual should not perform the behavior. The Persuasive Health Messages Framework (Witte, 1995) asserts that barriers to self-efficacy include beliefs that the behavior

- Is performed infrequently by others (especially among those with the same demographic profile).

- Is associated with immorality or disease.

- Is inconvenient.

- Reduces pleasure, virility, or desirability.

- May be seen as an admission that one is at risk of contracting HIV.

- Is not needed because the individual perceives him/herself to have low susceptibility to the risk.

- Is forbidden or otherwise discouraged by the church or other referent groups.

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The model shown below, Figure 12, highlights key components of the "potential barriers" domain of the conceptual framework and introduces a review of literature about factors that can discourage or otherwise hinder an individual from complying with an AIDS prevention recommendation.

Lack of Self-Efficacy

Individuals' perceptions of barriers are strong predictors of their resistance to adopting safer sexual practices (Aspinwall, 1991). Perceived barriers that inhibit various kinds of recommended behavior changes include costs (Price, Colvin & Smith, 1993), forgetfulness, unpleasantness, inconvenience, perceptions about one's inability to control sexual drives (Zimmerman, 1994), complexity, danger, duration, and potential negative impact of prescribed behavior on the lives of close others (Becker, 1974).

INDIVIDUAL PROCESSES
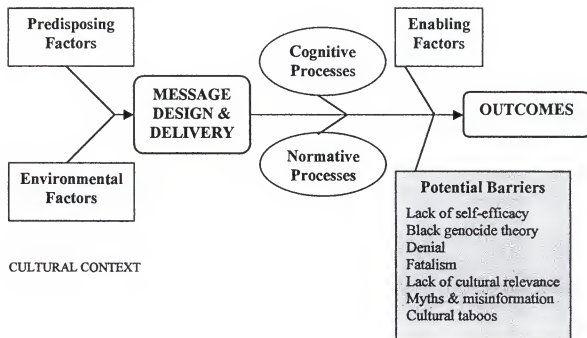
FIGURE 12: Barriers to Individual Compliance with AIDS Prevention Advice

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Grunig's (1983) situational theory posits that people who have heightened perceptions of barriers also are likely to seek less information and exhibit more defensive responses to challenging information than those with lower perceptions of barriers. However, Rimal and Flora (1996) found that enhancing self-efficacy does not always lower perceived barriers, as is generally assumed, because the acquisition of coping skills does not necessarily result in accomplishments.

The possibility of loss tends to loom cognitively larger than the potential for gain in the minds of most individuals (Tversky & Kahneman, 1974). The decision to enact a health behavior is much more susceptible to influences of losses than the decision to enact other kinds of behaviors (Rimal & Flora, 1996).

The most important barriers to achieving the desired cognitive, behavioral, and psychological outcomes in AIDS prevention among African Americans are failures to address the concerns that they perceive to be most serious, their lack of risk reduction skills, lack of resources, and lack of self-esteem and perceived control (Wofsy, 1987). Other barriers may include poverty, low literacy, and lack of access to health care. For example, the Blacks Educating Blacks About Sexual Health Issues program identified critical need youths as those who live below the poverty level, function below the normal academic grade level, have inadequate health insurance, and lack health care services (USCM, 1990).

Dalton (1989) contends that the attitudinal barriers to AIDS education among African Americans are rooted in five causes:

1. A societal sense of blaming African Americans for bringing the disease to America.

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2. Deep-seated suspicion and mistrust of any whites who express a sudden interest in them.

3. Homophobia, which can promote denial of homosexuality and bisexuality.

4. The phenomenon of drug abuse in the black community.

5. Tremendous resentment at being dictated to.

Black genocide theory

Stevenson and White (1994) found that a major barrier to effective AIDS outreach in minority communities is a distrust of majority culture institutions. Dalton (1989) noted that many African-Americans view the AIDS epidemic as genocide aimed at blacks. Many African Americans view the government's promotion of condom use as a way of limiting the growth of the black community (Spector, 1991).

Another black genocide belief is the conspiracy theory that HIV is a manmade weapon of racial warfare. This belief is rooted in distrust and suspicions surrounding the Tuskegee study of untreated syphilis in black males conducted 1932-1972 (Thomas & Quinn, 1991). During the 1970s, many blacks called the use of contraceptives a form of ethnic genocide promulgated by whites because they viewed the ability to reproduce as a powerful tool in the fight for liberation (Mays & Cochran, 1988). A New York Times/CBS telephone poll conducted in 1990 found that 10 percent of black respondents said that the AIDS virus was deliberately created in a laboratory to infect black people, and another 19 percent felt that the theory might possibly be true (DeParle, 1990).

Stevenson (1994) asserts that black genocide theory is rooted in the African American community's distrust of science. In a survey by Herek and Glunt (1993), 67 percent of African Americans, compared with 34 percent of whites, agreed that the U.S. government is not telling the whole story about AIDS. This distrust is based on two primary factors: that historically, mainstream societal institutions have systematically attacked the sexuality of African Americans for purposes of subjugation and control, and that assumptions of inferiority underlie "helping strategies" for African Americans (Stevenson, 1994).

Jemmott and Jones (1993) argue that the "legacy of racism" in the black community can cause African American individuals to distrust researchers

> Who seek to recruit them for studies and government officials and health authorities who provide AIDS-related information and recommendations. . . . Ethnic minority individuals may believe that they are being used as guinea pigs in experiments to try out procedures that would not be tried on whites (p. 216).

In a survey of participants in the 1990 Southern Christian Leadership Conference, Rosin (1995) found that more than one-third agreed that AIDS is a form of genocide against blacks, while more than a third believed that HIV was produced in a germ-warfare lab. Rosin observed that "suspicion and mistrust of mainstream medical institutions make it difficult to mount a communal response" to the AIDS epidemic in the black community (p. 21).

The "test tube" theory advocates the notion that the U.S. government developed HIV in a laboratory as a germ warfare weapon against foreign countries. AIDS was assumed to be the result of these errant U.S. germ warfare experiments. The theory

first emerged in 1986 in the Soviet press. AIDS experts have dismissed this notion, and Washington has accused the Soviets of waging a "disinformation campaign" (Time, 1986).

The theory also hinges on the June 9, 1969, Congressional Record, which reported that Dr. D. M. McArtor, then Deputy Director of Research and Technology for the Department of Defense, appeared before the House Subcommittee on Appropriations to request funding for a project to produce a synthetic biological agent for which humans have not yet acquired a natural immunity. McArtor asked for $10 million dollars to produce the agent over the next five to ten years. According to the plan for the development of this germ agent, the most important characteristic of the new disease would be "that it might be refractory [resistant] to the immunological and therapeutic processes upon which we depend to maintain our relative freedom from infectious disease." AIDS first appeared in the U.S. as a public health risk 10 years later.

Another "test tube" theory is a popularization of the "stealth virus" theory, which suggests that polio vaccines during the 1950s and 1960s were contaminated with a HIV-like virus that can reside within the body without being detected by the immune system. A partial sequence of this "stealth" virus is similar to the simian cytomegalovirus (SCMV), which has been found in the African Green monkey. African Green monkey kidney cells are used in the production of live oral polio vaccine. Some researchers believe that the "stealth" virus mutated into HIV (NIP, 1998).

While the "stealth virus" theory has not been confirmed through laboratory tests, the CDC did detect another monkey virus, Simian virus 40 (SV 40), in lots of injectable polio vaccines used prior to 1961. SV 40 has no relationship to HIV or simian

immunodeficiency virus (SIV, the virus that causes AIDS in monkeys), but the virus has caused cancer in laboratory animals. Since 1961, polio vaccine manufacturers have been required by the Food and Drug Administration to test for SV 40, even though studies in the U.S. and Sweden have shown no increased rates of cancer among humans who would have received polio vaccine between 1954 and 1962 (NIP, 1998).

Other theories about the origin of AIDS suggest that the disease made its initial lethal intrusion into the human population in Africa through contact with monkeys. The "green monkey" theory is well known because many geneticists have found wild African green monkeys to be naturally infected with SIV, a retrovirus related to HIV (Fukasawa, Miura, Hasegawa, Morikawa, Tsujimoto, Miki, Kitamura & Hayami, 1988). In some monkey species, SIV can induce an AIDS-like syndrome characterized by the early presence of viruses in the blood, frequent decrease in blood platelets, severe depletion of lymph tissues, opportunistic infections, and brain inflammation. It has caused death in 70 percent of monkeys within a year after infection (Hirsch, Dapolito, Johnson, Elkins, London, Montali, Goldstein, & Brown, 1995). Some scientists have speculated that humans could have become infected initially through monkey bites, eating tainted meat, or bestiality. The virus then may have been passed on to other humans via sexual contact and possibly by rituals involving tattooing or scarring of the skin.

AIDS services to African Americans likely will be unsuccessful if this distrust goes unrecognized. In addition, Thomas and Quinn (1991) contend that trust in public health authorities must be rebuilt through an open, scientifically sound, culturally sensitive discussion of genocide and the Tuskegee study. Mays and Cochran (1988) caution that white change agents tend to misinterpret resistance to AIDS prevention efforts among African Americans when

cultural differences influence the way targeted individuals articulate why those efforts are inappropriate.

Denial

Individuals tend to engage in denial or dismiss information when they are exposed to high fear appeals (Mays & Cochran, 1988). McGhee (1992) notes that black churches throughout the U.S. have mirrored the denial mentality among much of the collective black community by not dealing directly with the AIDS issue. Participants in church services and activities often see HIV as less significant, or as a less easily acknowledged problem, than unemployment, crime, drugs, homelessness, poor health care, and other urgent issues affecting community survival (Goldman, 1990). The lack of acknowledgment that many adolescents are sexually active is a primary social barrier to developing explicit, aggressive, and innovative AIDS prevention programs targeting youth (DiClemente, 1993).

Fatalism

A major barrier to perceived susceptibility is fatalism, the belief that people get AIDS only if they are predestined to contract the disease, and vice versa. Sources of fatalism include cultural myths, misinformation, apathy, depression, and emotional distress. When prevention information is presented in an overly fear-arousing manner, it increases the likelihood that individuals will adopt a fatalistic attitude (Mays & Cochran, 1988).

African Americans tend to become fatalistic when they depend solely on their black peer group for individual definition and fail to develop a separate self-image. This is because they tend to perceive their fate as inextricably linked to that of the group and internalize all

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images, characteristics, and treatments of the group as statements about their individual nature (Jackson, McCullough & Gurin, 1992).

In her study of cancer information, Freimuth (1990) found fatalism to be a major health-related cultural belief among African Americans. To counteract fatalism, an AIDS prevention message must emphasize that people from all walks of life are vulnerable to AIDS and offer concrete steps that individuals can take on their own behalf, embedded in the self-efficacy message that they have the power to take personal control in preventing transmission of the disease.

Lack of Cultural Relevance

Much AIDS prevention advice given to African Americans through government-sponsored, culture-free PSAs and brochures is not presented in culturally relevant language and does not account for the everyday situations they routinely encounter.

For example, they are asked to "negotiate" safer sex contracts in relationship situations by "talking with their prospective partners." This language makes advice sound complicated, and the wording itself may be difficult to comprehend for lower literacy audience members. In addition, the advice does not account for the fact that many African Americans may not bother to ask about previous sexual or drug use behaviors because they know their partners will lie or discount the risk. African American women are advised to have one lifelong sexual partner, even if they live in a community where men are scarce, relationship instability is the norm, and 65 percent of black women older than age 15 are not currently married (Mays & Cochran, 1988).

The advice of many mass audience public service announcements is based on the assumption that relationships are based on power equality and honesty. However, Mays and Cochran (1988) note that in many relationships each person is expected to keep past sexual

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behaviors a secret until the relationship has been well established. Further, disclosure may be an unaffordable luxury for those who do not have the money or other resources to guide their choices.

For African Americans, individualistic action appeals may not be as effective in motivating behavior change as messages built on a model of social responsibility that emphasize ethnically based values of unity, cooperation, and faith in a vision (Mays & Cochran, 1988). These values are emphasized through the African American holiday traditions of Kwanzaa. Specifically, the holiday celebrates core values of unity, collective work and responsibility, ethnic self-determination, cooperative economics, purpose, creativity, and faith.

Myths and Misinformation

Cultural barriers between African Americans and AIDS educators can reduce the exchange of information and the educators' ability to communicate the importance of preventive measures and the availability of services (Florida Health Net, 1997). Ignorance of AIDS, a major barrier to self-efficacy among African Americans (Leigh, 1995), includes myths and misperceptions regarding the transmission and origin of the disease (Stevenson & White, 1994).

A challenge in confronting the AIDS problem in the black church is the underlying public association of homosexuality with the disease, which Grossman (1991) calls a "double stigma." Mills (1992) notes that the predominant meaning assigned to AIDS is a profound fear and dread of homosexuality. Gleaton and Johnson (1995) comment that some black ministers urge gays to marry and have children as a way to "get over" their homosexual feelings.

DiClemente, Boyer, and Morales (1988) reported that African Americans and Latinos were more likely than whites to report that "All gay men have AIDS." Some black men believe they are not at risk for getting HIV as long as they do not engage in sex with a white gay male (Peterson & Marin, 1988). Schiller, Crystal, and Lewellen (1994) note that people with AIDS generally are portrayed in the media as either white gay men or street people abandoned by family and friends. This construction of HIV has led to distancing and denial of personal risk by people who don't relate to these "social deviants."

Taboos

A primary challenge in developing an AIDS prevention strategy is attempting to frame taboo topics such as illness, death, sexuality, and homosexuality. Sex in nearly all human societies is surrounded by taboos. Few people can discuss such a sensitive issue without making or implying moral judgments or feeling that others are making moral judgments about them. Further, when people from one ethnic group discuss AIDS and sexual behaviors within another ethnic group, it often arouses suspicions of racial prejudice (Gleaton & Johnson, 1995).

AIDS represents a dilemma for black churches that take a conservative view of moral issues such as homosexuality, promiscuity and drug use. Dalton (1989) argues that the African-American church, being fundamentalist and conservative, has stood in the way of AIDS education. African American fundamentalist religiosity often promotes attitudes of sexism, homophobia, proselytism, and intolerance for or erasure of individual difference (Perkins, 1995).

General AIDS prevention messages in black churches are often phrased in moralistic terms, condemning homosexual behavior, sex outside marriage, and drug use. Such messages sometimes conflict with existing, well-established behaviors. Moreover, because the majority of churchgoers are women, men often are isolated from these types of prevention messages (Goldman, 1990).

Rubin (1994) found that black churches are not adequately addressing many prominent issues facing African American adolescents. The needs and perspectives of youth and other at-risk individuals often go unheard within the African American religious community because of the stigma surrounding their behaviors. The culture in which risky behaviors are normalized must be changed before behavior change can occur (CAPS, 1993). Because sex outside of marriage, including homosexuality, fornication, adultery, and prostitution, is considered a sin, individuals who engage in these behaviors cannot be normalized until churches can accept, protect and incorporate them and create safe places where they can come for help.

Johnson (1987) found that factors leading to an attitude of intolerance of AIDS victims included: lower levels of education, low self-esteem, political conservatism, religious fundamentalism, and the belief that America has not appreciated the contributions of Christian fundamentalists. Ambrosio and Sheehan (1991) found that intolerance of people living with AIDS is linked to a "just world belief" in which people are blamed for their own misfortune.

St. Lawrence (1990) found that many college students hold highly stigmatizing, prejudiced attitudes towards AIDS patients, particularly when a patient is perceived as homosexual. Similarly, Pryor (1989) found that a symbolic connection between

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homosexuality and a disease victim may result in rejection of the victim. Although beliefs about contagion are unrelated to a desire to avoid an AIDS-infected person, attitudes toward homosexuality are significantly related to this avoidance behavior. Bishop (1991) argues that individuals who have a disease associated with homosexuals are perceived as being more responsible for their illness.

Outcomes

The Outcomes domain of the theoretical framework includes the various individual consequences of exposure to a behavior change message. "Outcomes" have different labels within different existing theories. Many refer to outcomes as "behavior" (Social Cognitive Theory, Theory of Reasoned Action, and Theory of Planned Behavior), while others refer to outcomes as "enactment" (i.e., AIDS Risk Reduction Model) or compliance (Health Belief Model). Gerbner's (1956) General Model of Communication highlights outcomes in the statement: "Someone – reacts – conveying content – of some consequence." Similarly, Diffusion of Innovation theory (Rogers, 1995) identifies decision, adoption, rejection, implementation, and confirmation as possible outcomes.

The Stages of Change model (Prochasta & DiClemente, 1984) identifies four types of outcomes expectations: physical risk behaviors, alternative behaviors (physical, social, or self-evaluative), social reinforcement of a new behavior, and self-evaluative reinforcement of the new behavior. According to the Input/Output Matrix (McGuire, 1989), the response steps that mediate persuasion include behaving in accord with a decision, post-behavioral consolidating, and yielding (attitude change).

The Transformation Model of Communication (Kreps, 1994) lists three types of outcomes: cognitive, behavioral, and physiological. Cognitive outcomes include

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understanding/knowledge, commitment to health, adjustment of health beliefs, confidence, satisfaction, trust, diagnostic information, self-efficacy, managed expectations, and fears/anxieties. Behavioral outcomes can include compliance with the recommendation, adoption of preventive/health promoting behavior, assertiveness, communication competence, motivation, and relational quality between source and receiver. Physiological outcomes can include disease prevention, long-term survival, quality of life, and maintenance of desired health.

The cognitive structure change process described by the Elaboration Likelihood Model of Persuasion (Petty & Cacioppo, 1981) posits that when cognitions are adopted, stored in memory, and made salient, they either lead to enduring positive attitude change (persuasion) or to enduring negative attitude change (boomerang effect). Similarly, the Extended Parallel Process Model (Witte, 1996) identifies adaptive vs. maladaptive changes.

The model shown below, Figure 13, highlights key components of the "outcomes" domain of the conceptual framework. The following section discusses the types of attitudinal and behavioral outcomes that can result from an individual's response to an AIDS prevention message.

Predictors of Behavioral Outcomes

Unlike product marketing campaigns, health campaigns aim to change fundamental behaviors rather than mobilize an existing predisposition (i.e., switching brands). While product advertisers are typically satisfied with small shifts in market share, health campaigns aim to change a large proportion of the population and do so by targeting specific, well-defined sub-groups (Flay & Burton, 1990).

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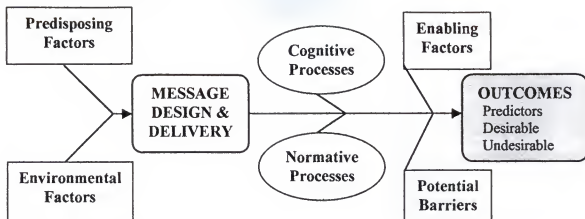
FIGURE 13: Responses to AIDS Prevention Advice

A major role of behavioral theory is the prediction of outcomes. Predictive theories generally state that "if x occurs, then y is more or less likely to occur" (Maibach & Parrott, 1995, p. 1). A person's intention to perform a given behavior is the best single predictor of whether or not the person will perform the behavior (Fishbein, 1980). However, predictions of behavior often can be improved by measuring intentions with respect to all of a person's alternative courses of action, particularly when attempting to predict habitual behaviors such as sexual activity, drug use, or drinking (Petty & Cacioppo, 1981).

Bandura (1986) posits that outcome expectations can take the form of physical effects (outcomes that could increase or decrease health or the pleasures of living), social effects (incurring approval or disapproval of others), or self-evaluative effects (incurring approval or disapproval of self). People develop their outcome expectations "through some combination of direct experience, observational learning, and persuasive communication" (Maibach & Cotton, 1995, p. 50). Jemmott and Jones (1993) identified four types of outcome expectancies that are of particular interest to those designing AIDS

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prevention campaigns targeting African American youth: altered risk of harm, hedonistic costs or benefits (effects on sexual pleasure and/or fun), social sanction, and social approbation.

In predicting college students' intentions to engage in premarital sex, Fishbein (1966) found that for females, the attitude component (their own view of the consequences) was more important in determining intentions than the subjective norm (others' views), but for males, the subjective norm component was more important than attitude.

The stronger a person's judgments of self-efficacy and response efficacy for a particular behavior, the more likely he or she is to have positive outcome expectations. Even if individuals believe a behavior will lead to desirable outcomes, they are not likely to be motivated to attempt it if they have no confidence that they can perform the required behavior (Bandura, 1986).

Personal goals are major sources of motivation because they "provide both a direction and reference point against which people can compare their progress" (Maibach & Cotton, 1995, p. 50). When a behavior is enacted or maintained at a level that meets the goal, a person tends to be satisfied and have positive self-appraisals; conversely, when a person fails to progress towards a goal, he or she will tend to be dissatisfied and have negative self-appraisals. When goals are attained, people often adjust their goals upward and increase their level of effort; when they fail to progress, they usually will renew their effort toward attaining the original goal (Maibach & Cotton, 1995).

Subjective expected utility models predict that outcomes are a function of several variables. For example, Rogers' (1975) protection motivation theory posits that

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persuasive outcomes are a multiplicative function of the perceived vulnerability, perceived severity, and response efficacy. If any of the three variables took on a zero value, the fear appeal would not be persuasive.

In addition to their complexity, attitudes, values and behavioral tendencies are acquired gradually. Zimbardo, Ebbesen and Maslach (1977) argue that individuals grow rather than change:

> We are not succumbing and being persuaded, coerced, or induced to be other than we are. Rather, we perceive that we have chosen freely to become our own person. It is the recognition of a change that seems more sudden, abrupt, and discontinuous than normal that raises the possibility of external, special forces at work. An action that violates what seems appropriate, or that does not fit our expectations, is more likely to be thought of as "coercion" (p. 1-2).

Desirable Outcomes

Outcome or effectiveness evaluation focuses on determining whether health campaigns or messages successfully achieve the desired outcomes. From the perspective of a campaign planner, each possible behavioral outcome will be either desirable or undesirable.

The long-term maintenance of individual change usually requires behavior changes by the bulk of the targeted population, not just the 5 to 10 percent that are most easily influenced by mass media campaigns. Thus, government and community involvement are essential to help promote the long-term practice of recommended behaviors (Flay & Burton, 1990).

Although behavior change and long-term maintenance are the ultimate desired outcomes of a behavior change campaign, various interventions within a campaign may strive to achieve outcomes that are lower on the hierarchy of possible positive effects.

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Cartwright (1949) identified three psychological processes in behavior change in campaigns: cognitive structures (knowledge), affective structures (motivation), and action structures (behavior). Media campaign messages supported by face-to-face communication are more likely to lead to recommended behavior changes because the combination of these channels is more likely to activate all three types of psychological structures (Flora, Maccoby, & Farquhar, 1989)

According to McGuire's (1989) Input/Output Matrix, positive outcomes can include yielding (attitude change), decision on basis of information retrieval, behavior in accordance with a personal decision, reinforcement of desired acts, and post-behavioral consolidating. The behavioral objectives of the Stanford Community Studies included helping individuals "become aware, increase knowledge, increase motivation, learn and practice skills, take action, assess outcomes, maintain action, practice self-management skills, and influence social network members" (Flora, Maccoby, & Farquhar, 1989, p. 235).

Other campaign effects can include awareness of the consequences of noncompliance, self-efficacy, cognitive management of fears and expectations, assertiveness or communication competence, changes in perceived susceptibility or perceived threat, changes in social norms that affect behavior, and verbal commitment to behavior change.

The desirable outcomes of a *fotonovela* intervention might include:

- Verbal expressions of interest in AIDS issues

- Awareness or knowledge of AIDS-related behavioral risks

- Changes in social norms within church networks (overcoming denial)

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- More open discussion about preventive behaviors between adults and teens

- Behavior change: Sexual abstinence or the postponement of sexual involvement.

Undesirable Outcomes

Undesirable outcomes, inevitable in any behavior change campaign, vary depending on the type of recommended behavior. In a *fotonovela* campaign in which teens are urged to postpone or otherwise abstain from sexual involvement in order to avoid disease, the undesirable outcomes might include:

- Sexual involvement: initiation, continuing, or relapse.

- Withdrawal from social support networks.

- Reduced interest in AIDS issues.

- Confusion about AIDS transmission.

- Denial of personal risk.

- Self-devaluative behaviors.

Bandura (1994) posits that self-reactive control prompts people to refrain from transgressing because the conduct would lead to self-reproach. For people whose behavior is regulated by social sanctions, they refrain from self-serving or reprehensible conduct for fear of being ostracized.

When people are socially pressured to engage in behavior that violates their moral standards, social influences will have little sway as long as the perceived self-devaluative consequences outweigh the benefits for choosing socially accommodating behavior. When faced with an ethical dilemma, however, people often modify their personal framework of moral standards to regulate their conduct, and the remaining self-sanctions

can be nullified if certain internal controls are disengaged. In the present study, a self-devaluative behavior might be the decision to have sexual intercourse despite internalized religious beliefs that label such behavior as sinful.

Bandura contends that most people avoid conduct that produces self-devaluative consequences such as guilt. People usually do not engage in deplorable conduct until they have justified to themselves the morality of their actions. When people rationalize their own self-deplored conduct, it leads to cognitive restructuring, which may include:

- Euphemistic labeling, or justification by a "high" moral principle.
- Minimizing, ignoring, or misconstruing the consequences.
- Dehumanizing or blaming victims.
- Reducing or displacing personal responsibility for the act.
- Making palliative comparisons, which contrast a self-deplored act with other more deplorable acts committed by others.

Summary of Literature Review

The purpose of the preceding literature review, as presented within the eight domains of an organizing theoretical framework, was to describe the conceptual dimensions of processes and factors that could influence an individual to comply with AIDS prevention advice. The present study explored the barriers and inroads to dialogue about this prevention advice in various religious contexts among African American youth and women.

While the organization of concepts was a broad synthesis of the structural components of existing health behavior change models and other related theories, the empirical evidence presented within this framework focused on the AIDS-related behaviors

and attitudes of African Americans, particularly among adolescents. In addition, the general model that emerged from the synthesis of existing literature later was used as an organizing framework for data analysis.

The following chapter will describe the methodology of the present study, including site selection justifications, research questions, study objectives, and procedures used in the collection of data through participant observation, long interviews, and focus groups. The chapter also will explain how research participants developed a *fotonovela*, as well as how the investigator conducted readability analysis, provided informed consent, evaluated validity threats, and transcribed, analyzed, and interpreted the data-texts.

CHAPTER 3
METHODOLOGY

The primary goal of this study was to explore the inroads and barriers to AIDS

prevention dialogue within various religious contexts in the African American

community, in order to develop strategies for educating youth about their behavioral risks

of contracting the disease. On an individual level, the various predisposing factors,

enabling factors, cognitive processes, and outcomes of exposure to an AIDS prevention

message were explored, as well as the culture-level environmental, message design, and

normative processes that can influence individual choices. A three-tiered approach was

used to examine these health behavior domains:

(1) Participant observations of church meetings, HIV prevention activities, and other

   public events in the African American community.

(2) In-depth interviews with clergy, AIDS organization leaders, and church members.

(3) An iterative focus group design that encouraged youth and women to express their

   ideas and views about AIDS-related issues throughout the process of creating,

   evaluating, and disseminating an AIDS prevention *fotonovela*, a photo-illustrated

   story booklet, to youth within their social networks.

   The flowchart on the following page, Figure 14, presents the basic strategy and

sequence of data collection procedures used in this study:

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┌─────────────────────────────────────────────────────────────┐
│                  PARTICIPANT OBSERVATION                      │
│  •  20 monthly meetings of an African American AIDS task force. │
│  •  4 church services, including a funeral for a man who died of AIDS. │
│  •  2 AIDS awareness tabling events during ethnic festivals.  │
│  •  3 youth group meetings in African American churches.      │
│  •  An AIDS awareness breakfast for African American ministers. │
│  •  An AIDS workshop for African American, Baptist deaconesses. │
│  •  An AIDS awareness fair in Washington, D.C., sponsored by several inner city │
│     African American churches.                                │
└─────────────────────────────────────────────────────────────┘
                              │
                              ▼
┌─────────────────────────────────────────────────────────────┐
│                      LONG INTERVIEWS                          │
│  •  2 clergy (male from small church, female from large church). │
│  •  4 female church members.                                  │
│  •  3 leaders from an African American AIDS task force.       │
│  •  3 leaders of AIDS programs targeting black churches in Washington, D.C. │
└─────────────────────────────────────────────────────────────┘
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┌─────────────────────────────────────────────────────────────┐
│                       FOCUS GROUPS                            │
│  •  Pilot study focus groups with 2 groups of adolescents: 10 boys and 10 girls. │
│  •  3 iterative rounds of focus groups with 2 groups of teens: 18 boys and 29 girls. │
│  •  2 iterative rounds of focus groups with one group of 18 women. │
└─────────────────────────────────────────────────────────────┘
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FIGURE 14: Strategies and Procedures of Data Collection

Selection of Method

Qualitative research methods were selected for the present study because the

disproportionate level of HIV infection among African Americans, coupled with the lack

of effective AIDS prevention interventions targeting this population, call for more

exploratory research about the cultural norms that can influence behavior change efforts.

Compared with quantitative methods, qualitative research can provide deeper

understanding of the context and language of behavior in a community, and it is better

suited to illuminate motivations, enable discovery, interpretation, and exploration, and

provide holistic insight and more fruitful explanations of trends (Smith & Debus, 1992).

Qualitative research has been useful for understanding social conditions associated with the spread of HIV as well as for developing culturally and socially targeted means to reduce infection (Bletzer, 1993; Bolton & Singer, 1992; Cruise & Dunn, 1994; Weeks, 1993). Smith and Debus (1992) advocated the use of qualitative methods to blaze new trails in prevention research:

> The AIDS epidemic dramatizes what we do not yet know about human sexuality, exposing the limitations of our behavioral research technology and challenging us to develop new ways to learn about some of humanity's most private and taboo behaviors. To help people protect themselves from HIV infection we must offer alternative practices which are acceptable to those at risk. We must present information in ways which not only inform but persuade. We must find the means to overcome fear, prejudice and denial among groups of people who feel victimized and ostracized by society as a whole. This task requires not only good epidemiology and excellent survey research; it demands that we find new ways to collect data and understand the relationship of knowledge and attitudes to the behaviors which place people at risk of HIV infection. (p. 57)

Atkin and Freimuth (1989) assert that formative evaluation researchers should "attempt to learn as much as possible about the intended audience before specifying goals and devising strategies" (p. 134). Planners of community-based health campaigns have increasingly emphasized research using qualitative methodologies to enhance the potential for achieving social and behavioral change (Palmer, 1981; Windsor, 1984). Based on a model of action anthropology (Gearing, 1960), this study attempted to assess a norm of community self-determination by involving African Americans in the design and implementation of an intervention and by encouraging dialogue that can facilitate greater awareness, mutual concern, and behavior change.

In an effort to understand the lives of individuals from each person's perspective, McCracken's (1988) "lived text" approach to interviewing was used. Fisher (1984)

theorizes that people are inherently storytelling animals, and telling narratives about the significance of events in their lives enables them to create meaning from chaotic events. An understanding of how African Americans talk and think about AIDS in their community is negotiated between each individual and the researcher. This ethnographic approach seeks to validate the subjects' cultural context and requires the explicit acknowledgment of the interaction between the researcher's own cultural template and the "culture" being studied.

The planners of the Blacks Educating Blacks About Sexual Health Issues program in Philadelphia included the development of prototype educational materials for review by focus group participants (USCM, 1990). This study was based on the BEBASHI model, in that three layers of focus group feedback as well as long interviews and participant observation are used to develop and refine a *fotonovela* for use as an HIV education tool.

Data collection methods for the current study include participant observation, as well as in-depth, ethnographic interviews with both individuals and focus groups.

Site Selection

Gainesville, Florida, was selected as the site for this case study. Gainesville has a population of 89,500 and 33,700 households (SRDS, 1997), and it is located in Alachua County, a rural, agricultural county in north central Florida with a population of 196,106. About 57 percent of the Gainesville population and 26 percent of Alachua County's population are students, faculty, and staff of the University of Florida, and an additional 16 percent of Gainesville's population is comprised of students, faculty, and staff of Santa Fe Community College (Alligator, 1997).

Gainesville was chosen as the site for this research for nine primary reasons. Additional background information and other supporting details are provided in the discussion below the list. Many of the rationale statements for these nine items relied on county or state statistics when city data was not available.

1. **African American population:** Nearly 1 in 5 residents of Alachua County are African American, and a fourth of the African American population are teens that may be at risk of HIV infection.

2. **AIDS rates:** Florida is annually ranked third in the nation in number of AIDS cases. In Alachua County, an AIDS rate of 246 per 100,000 ranks 19th – within the top third of 67 counties. This means that 246 individuals per 100,000 have been diagnosed with AIDS, which is 13 percent higher than the national rate. For the 25-34 age group, more years were lost due to AIDS in 1996 than deaths from all forms of cancer, cardiovascular disease, accidents, homicides, suicides, and all other causes.

3. **Disproportionate AIDS incidence** among African Americans: Statewide, 43 percent of AIDS cases are among African Americans, compared with 35 percent nationally. The rate for blacks is almost three times greater than the rate for Hispanics. African Americans represent the highest number of diagnosed cases of AIDS for female teens, and the second highest for male teens. More than seven times as many black children as white children have AIDS, and 81 percent of all pediatric AIDS cases are black. Four times as many black women as white women have been diagnosed.

4. **Behavioral risks:** Local and state statistics about unwed pregnancy rates, drug use, and intention to commit suicide indicate the extent that individuals may engage in HIV-related risky behaviors.

5. **Lack of eligible African American males** could be a potential risk factor in Alachua County, particularly among women, because the ratio of African American females to males increases dramatically as they get older.

6. **Truancy:** Twice as many African American youths than white youths in Alachua County drop out of school before the 9th grade. The county's dropout rate is nearly 80 percent higher than the average dropout rate in Florida. One in five African American adults in Alachua County never finish high school.

7. **Economic disadvantage:** Among African Americans 16 and older in Alachua County, nearly a third are unemployed or otherwise do not work. About 38 percent of all African Americans in the county live below the poverty level.

8. **African American AIDS Task Force:** The development of this study was guided by the advice and observation of the African American AIDS Task Force, a Gainesville volunteer group that designs and implements AIDS prevention and education initiatives within the black community. This study was intended to help AAATF meet several of the goals established during the group's first, organizational meeting:

   - To involve African American youth as peer educators and in brainstorming and developing AIDS education materials.

   - To create a quality, culturally sensitive brochure.

- To help reduce the stigmatization of HIV/AIDS in the African American community.

- To help mobilize the churches, starting with the most progressive ministers.

9. **Local mass media:** The niche for a *fotonovela* intervention was highlighted by an examination of Gainesville's mass media organizations. This information was included because prior literature has shown that AIDS knowledge and beliefs are associated with media access and use.

African American Population

About 19 percent or 34,539 Alachua County residents are African American (U.S. Bureau of the Census, 1996). Minority youths under 18 years of age comprise a third of the population, and a fourth of the African American population in the county are teens who may be at risk of HIV infection. About 12 percent of the 34,539 African Americans in the county are ages 12 to 17, and 13 percent are ages 18 to 24. A quarter is aged 25 to 44, the age group reporting the highest number of AIDS cases (U.S. Bureau of the Census, 1997). In the 12 to 24 age group, the target of the *fotonovela* intervention in this study, 4,596 of Alachua County African Americans are females (13 percent) and 3,943 are males (11 percent), for a total of 8,539 potential target audience members (U.S. Bureau of the Census, 1990).

AIDS Rates

Florida ranks third, behind New York and California, in the number of cumulative AIDS cases, and ranks second in the number of pediatric AIDS cases. In December 1997, the state reported 58,911 AIDS cases since 1981, a rate of 606 per 100,000 population. Miami ranks fourth in the top 10 list of metropolitan area infection

rates, and the city accounts for 30 percent of cases in the state, which means one in 40 adults there may be infected (CDC, 1996). Although state law prohibits Florida public health officials from reporting HIV incidence to the public, they estimate that 137,500 residents probably are infected (Florida Health Net, 1997).

In 1996, a 25 percent drop in AIDS-related deaths, across all ethnic groups, was attributed to the increased use of anti-retroviral drugs and other preventive therapies. This decline, the first since the epidemic began in 1980, is expected to continue given the use of protease inhibitors, a particularly effective class of new anti-HIV drugs that were not widely available until the middle of 1996 (Kertesz, 1997). The 25 percent drop in Florida is more than double the decline in AIDS deaths reported nationwide, and more than three times the drop in the South (Facts on File, 1997).

From 1981 through 1996, Florida has reported 60,710 AIDS cases, 58 percent of whom have died. Of these cases, 44 percent were infected through male to male sexual contact (compared with 50 percent nationally); 18 percent through injection drug use (26 percent nationally), 15 percent through heterosexual contact (9 percent nationally); 5 percent through male to male contact involving injecting drug use; 2 percent of the cases were transfusion related; and less than 1 percent were hemophiliacs. Eighty percent of adult AIDS cases are among men.

These state figures do not account for the people who have tested positive for HIV infection, but only for those diagnosed with full-blown AIDS. Public health officials speculate that for every case of AIDS reported, three other Floridians are

infected with HIV. In Alachua County, this would mean that 1 in 130 people were infected with the virus by 1997 (Florida Department of Health, 1997).

Among male AIDS cases, 24 percent of African Americans reported they were infected through male-to-male sexual contact, compared with 76 percent of white cases. One-fourth of blacks were infected through injecting drug use, compared with 8 percent of whites, and 6 percent of blacks contracted AIDS through male-to-male contact and injecting drug use, compared with 7 percent of whites. About 7 percent of blacks contracted AIDS through heterosexual contact, compared with 1 percent of whites. The exposure factor was undetermined for 26 percent of blacks, compared with 5 percent of whites.

Among women, 29 percent of blacks reported that they had contracted AIDS through injecting drug use, compared with 38 percent of whites; 16 percent of black women were infected through heterosexual contact with an injecting drug user, compared with 18 percent of whites; 26 percent of black women contracted the virus through other heterosexual contact, compared with 25 percent of white women. The remaining 29 percent of black women either did not report a risk factor or had more than one risk factor. Among mothers giving birth, the HIV seropositivity rate is 470 per 100,000 (Florida Department of Health, 1997).

The AIDS rate in Alachua County is 246 per 100,000 population, which is 13 percent higher than the national rate. As of October 1997, Alachua County reported 405 cumulative AIDS cases, which means that 1 in 390 residents were diagnosed with AIDS by that date. Although Alachua County ranks 20th in population among Florida counties,

its current AIDS rate of 246 per 100,000 ranks 19th – within the top third of 67 counties. This rate is 57 percent higher than it was in 1992. The first AIDS case was reported in Alachua County in 1983, and county health officials have seen an exponential growth in the number of cases each year since then. The number of cases doubled between 1987 and 1988 and tripled between 1992 and 1993.

In examining the impact of premature and preventable mortality in Alachua County, the Florida Health Department (1997) found that 743 years of potential life have been lost before age 65 due to AIDS deaths, which accounts for 9 percent of years lost due to all causes of death. The AIDS deaths in the 25 to 34 age group account for more than 5 percent of all years lost, and 61 percent of years lost due to AIDS. For this age group, more years were lost due to AIDS than deaths from all forms of cancer, cardiovascular disease, accidents, homicides, suicides, and all other causes.

Disproportionate Incidence among African Americans

The disproportionate incidence of HIV and other STDs in Alachua County indicates that AIDS could reach epidemic proportions in Gainesville. In 1996, the county's cases of gonorrhea, chlamydia, infectious syphilis, and tuberculosis exceeded the average per-county cases (Florida Department of Health, 1997).

Melanie Gasper, former executive director of the North Central Florida AIDS Network, listed the primary HIV risk factors for African Americans in Alachua County as substance abuse, heterosexual infection, homosexual infection, and multiple risk factors related to prostitution. The North Central Florida Health Planning Council further identified three groups in this region that should be targeted with AIDS prevention

efforts: minority populations, especially African Americans, women of childbearing age, and at-risk youth (Gromley, 1996). These trends were shown by reports from AIDS case workers.

The number of cumulative AIDS cases among African American women between ages 15 and 44 in North Central Florida was three times greater in 1995 than in 1990. As of June 1996, 60 percent of the women of childbearing age in this region who have been diagnosed with AIDS are African American (HRS, 1996). In Alachua County, childbearing women test positive for HIV antibodies at a rate of 270 in 100,000 (Florida Health Net, 1997). Florida public health officials estimate that African Americans will account for more than half the state's cases by the year 2000 (Bergstrom, 1997).

Behavioral Risks

The rate of unwed pregnancy can indicate the extent of risky sexual behaviors among youths. About 75 percent of teenage mothers in Florida in 1992 were not married at the time of the birth. Among sexually active Florida adolescents, 67 percent reported using no contraceptive, reported using the withdrawal method, or did not know if any contraception was used during sex. In Alachua County, 3 percent of females under 18 gave birth in 1994, which is the same as the statewide average. In Florida, 18 percent of the girls who gave birth before age 18 had a repeat birth in 1994 (Florida Health Net, 1997).

Suicidal behavior, evidence of severe depression, has been shown to be a predictor of risky HIV-related behavior among youths. Among Florida teens in all racial categories, 24

percent said they had considered suicide seriously in the past 12 months (Florida Health Net, 1997).

Drug use is another major risk factor, particularly among teens. In Florida, 35 percent of male teens and 26 percent of female teens reported having had five or more drinks in a row within the previous 30 days, while 17 percent of teens reported using marijuana within the previous 30 days (Florida Health Net, 1997). Among blacks diagnosed with AIDS in Florida through 1996, 25 percent were infected through injecting drug use, compared with 8 percent of whites. Among African American women, 29 percent reported that they had contracted AIDS through injecting drug use, and 16 percent were infected through heterosexual contact with an injecting drug user (Florida Department of Health, 1997).

Lack of Eligible African American Males

In Alachua County, African American females account for 54 percent of the black community, while males account for 46 percent. The ratio of African American females to males increases as they get older: for those 12 to 17 years of age, the ratio is even, 1.0; for those 18 to 24, 1.3; for the 25 to 44 age group, 1.2; for those 45 to 64, 1.4; and for those 65 and older, 1.6 (U.S. Bureau of the Census, 1990). While the female-to-male ratio is even among adolescents under 18, young women between ages 18 and 24 are most affected by a sex-ratio imbalance. Given that this problem is widely recognized and lamented among African American women of child-bearing age, adolescent girls may feel pressured to "get a man at any cost" while they still have the chance. Knowing that fewer eligible men will be available in the near future,

they may give in to unsafe sex to initiate and maintain a relationship or to gain the prestige of being "kept" (Mays & Cochran, 1988).

Truancy

Truancy is another serious problem among youths in Alachua County. About 8 percent of African Americans in Alachua County drop out of school before the 9th grade, compared with 4 percent of whites (U.S. Bureau of the Census, 1997). African American children constitute about 35 percent of enrollment in the Alachua County school system, which serves about 24,000 students in 21 elementary schools, six middle schools, and six high schools (Resnick, 1992). The dropout rate for the 1995-'96 school year in Alachua County was 6.4 percent, which reflects a 73 percent increase since the 1991-'92 school year and is nearly 80 percent higher than the average dropout rate for the state (Florida Department of Education, 1997).

In Alachua County, 83 percent of all residents over 25 in 1996 had a high school diploma, and 35 percent were college graduates. Among African Americans over 25 years of age, 20 percent did not complete high school (compared with 14 percent of whites); 32 percent had a high school diploma but no college education (compared with 86 percent of whites); and 19 percent were college graduates, compared with 48 percent of whites (U.S. Bureau of the Census, 1997).

Economic Disadvantage

Alachua County has a large economically disadvantaged population. The unemployment rate overall averaged 3.7 percent in 1996 (U.S. Bureau of the Census, 1997). However, among African Americans 16 and older, nearly a third are unemployed

or otherwise do not work. About 24 percent of all residents and 38 percent of all African Americans live below the poverty level. More than 17 percent of African Americans earned less than $15,000 in 1989, and their average per capita income that year was $6,448. Similar to national statistics, 73 percent of all black families living below the poverty level in Alachua County are headed by a female with no husband present, while married-couple families account for 11 percent (U.S. Census, 1990).

In Alachua County, 87 percent of all residents living below the poverty level do not have access to dental care, compared with 76 percent statewide (HRS, 1994). Access to dental care is important in AIDS prevention and treatment because thrush and other oral manifestations of AIDS are often the earliest indications of HIV infection.

In Florida, 46,000 individuals are believed to be homeless, which is 1 in 354 residents (Florida Health Net, 1997). If the state homelessness rate were applied to Alachua County, an estimated 554 would be homeless today, and the national rate implies that nearly 5,900 county residents would have been homeless at some point in their lives – 1 in 392 residents.

African American AIDS Task Force

This study was intended to dovetail with the mission and long-range goals of the newly formed African American AIDS Task Force, an organization in Gainesville, Florida, which designs and implements AIDS prevention and education initiatives within the black community. The principal investigator gained entry into the African American AIDS Task Force through information-gathering conversations with several key informants. In a conversation that occurred several weeks before the task force was

launched, the executive director of the North Central Florida AIDS Network described her agency's strategy in recruiting prominent leaders from the African American community and invited the investigator to participate. The investigator chose an overt research role in the group and presented a brief overview of her dissertation agenda during the third meeting of the task force.

As a grassroots effort, HIV prevention in the U.S. consists of local organizations developed to respond to many aspects of the epidemic, including prevention, care, support, and advocacy. The activity of these organizations has yielded volunteer commitment and an intimate knowledge of at-risk communities (Stryker, 1995).

The African American AIDS Task Force in Gainesville, Florida, is a grassroots network committed to the empowerment of the African American community in controlling the spread of AIDS and reducing the stigma of the disease. According to the organization's mission statement, AAATF is

> Seeking inroads to serve the church community through culturally sensitive AIDS programs and seminars, tailored to address moral and religious standards, which foster care, compassion, education, HIV prevention, training, information, and referrals.

Launched in November 1994 by the North Central Florida AIDS Network (NCFAN), the task force meets one night a month to develop objectives and implement plans for community AIDS prevention and outreach activities. Melanie Gasper, executive director of NCFAN, commented that her organization "understands that involving influential members of the African American community ensures that culturally sensitive decisions will be made in all phases of planning and implementation, and that in all efforts, chances for success will be improved."

The task force includes health care professionals, ministers, social workers, attorneys, law enforcement officers, educators, community leaders, and other citizens. Gwen Love, one of 12 African Americans who helped launch the task force, remarked during the group's first meeting that many African Americans:

> Feel like they've been left out of the system. They need to know and feel the support of family and community. They need the basic tools to survive, but often they're too proud to ask.

During the first meeting, AAATF members brainstormed goals for educating local minority youth about AIDS. The following nine goals were scribbled on a flipchart by volunteer leaders of the organization:

1. Involve African American youth:
   - As peer educators
   - In brainstorming and developing AIDS education materials.

2. Provide AIDS education materials and curricula for Headstart and K-12 schools.

3. Create a quality, culturally sensitive brochure.

4. Mobilize the churches, starting with the most progressive ministers.

5. Help reduce the stigmatization of HIV/AIDS in the African American community.

6. Select African American role models that can be trained as AIDS educators.

7. Request mission offerings at local churches.

8. Develop television and radio PSAs promoting AIDS information and services.

9. Develop a video with rap music to appeal to teens.

Mass Media

Campaign planners should consider the social environment and lack of media

access among low-income African American adolescents when selecting channels and designing messages targeting these individuals.

In general, adolescents do not read newspapers, and public service announcements on radio, television, and posters often are too short to provide enough informative details to audience members. Many PSAs also fail to reach individuals because they are aired too infrequently, outside prime time, or on noncommercial stations, or because they often must be directed at a broad audience.

By contrast, the *fotonovela* format has numerous advantages over traditional mass media channels: it is much less expensive to develop, test, and produce than a radio, television, or film production, it does not require the use of electronic equipment, it has the potential for more lasting impact because it is more likely to remain in the readers' possession and less likely to be discarded, it is more effectively disseminated to a target audience than traditional print materials because of its greater potential to informally circulate within existing community networks, it is more likely to be in demand among those who read similar materials for entertainment, and it can be read at an individual's convenience.

The *fotonovela* also has the capacity to be "translated" into mass media formats and thus can be integrated into multi-media AIDS prevention campaigns. For example, a *fotonovela* script can be adapted for use as a radio spot (*radionovela*), video script (*telenovela*), or its script and accompanying photographs can be published as a poster, or in a magazine, newspaper, web site, or other print format. In addition, *fotonovelas* can

be distributed through the same channels as traditional pamphlets, such as tabling events (i.e., festivals and health fairs), school curricula, direct mail, and health care offices.

The potential niche for a *fotonovela* as an AIDS prevention information channel as part of a multi-media campaign in Gainesville, Florida, is highlighted by facts about the city's mass media organizations, as well as previous research about the use of these types of media channels among African Americans.

In a Midwestern university town similar in size to Gainesville, a recent media use survey showed that 30 percent of African Americans over age 18 used newspapers more than any other media. Although 70 percent used television more than newspapers or radio for news and information, they used newspapers more than television to get local news. Most African Americans in this town used television for entertainment and radio for music, and 70 percent said they used newspapers more for advertisements about food and clothing than for news (Perry, 1996). The results of this study imply that *telenovelas* might be most effective in reaching African Americans who watch television for entertainment, particularly if the spots were aired during the entertainment programs with the highest number of adolescent African American viewers. In addition, a *fotonovela* published in local newspapers might reach the greatest number of people if it were printed or inserted on the day of the week that the papers have grocery coupons.

The Gainesville community is served by numerous media organizations that could support a multi-media, *novela* AIDS prevention campaign targeting African American teens: two daily newspapers, a bimonthly African American newspaper, two network

television stations, a public broadcasting television station, an African American radio station, two Christian radio stations, and 15 other radio stations.

The daily newspapers are the *Gainesville Sun*, a New York Times Regional Group morning-delivery newspaper with a circulation of 51,378 (SRDS, 1997), and the *Independent Florida Alligator*, a student-run, free, weekday newspaper with a self-reported circulation of 32,000 (Alligator, 1997). Mass media channels that target African American audiences include the *Mahogany Revue*, a bi-monthly newspaper, and Magic 101.3, a soul-format radio station. The station manager, an active leader of the African American AIDS Task Force, frequently has donated free air time for AIDS PSAs.

Research Questions

Given the exploratory nature of the qualitative methodologies in the present study, it was difficult to predict all relevant research topics or settings that could arise during data collection. However, the development of data collection instruments and selection of methods were guided by four key research questions:

1. What are some specific inroads and barriers to AIDS dialogue within the African American church?

2. What are differences and similarities between the processes by which women and youth engage others in interactions about AIDS, and in what settings does this kind of dialogue occur?

3. Among youth, what factors serve as barriers to their postponement of sexual involvement or abstinence?

4. What enabling factors could empower youth to practice abstinence-based AIDS preventive behavior?

These four questions were explored using a triangulation of participant observations of religious and AIDS prevention activities, in-depth interviews with clergy, church members, and AIDS organization leaders, and focus group interviews with low-income youth and women. The following discussion provides a rationale, philosophy, and logistical details for each of the methods used in this study.

Participant Observation

Participant observation is a fundamental technique in ethnographic research that is concerned with the observation of naturally occurring behavior in natural contexts rather than in scientifically manipulated contexts.

In the present study, the investigator was an active participant observer, in the sense that she became involved in a key group rather than trying to operate anonymously. The researcher served as a volunteer consultant in coordinating community AIDS education projects for the task force. In addition, she entered the field setting with an openly acknowledged investigative purpose, but conducted the study from the vantagepoint of an official position within the membership.

Participant observation was conducted in order to inform strategies for the *fotonovela* intervention, whereas the in-depth interview and focus group methodologies described below were conducted in order to help inform theory modification and development.

Participant observations were recorded for about 20 monthly meetings of the African American AIDS Task Force (AAATF), five Sunday worship services, two AAATF tabling events during ethnic festivals, three church youth group meetings, a

multicultural Bible study in a predominantly white church, a faith community breakfast sponsored by the AAATF to raise awareness of AIDS issues among religious leaders, as well as five planning meetings for that event, a 30-minute AIDS workshop for Baptist deaconesses, and a health fair in inner city Washington, DC, sponsored by several metropolitan African American churches.

When possible, observations were recorded in brief field notes at the site and in expanded field notes on the same day that the observation took place. The method allowed the researcher to focus attention on particular scenarios while recording and participating in those scenarios. For example, the researcher helped a subcommittee of the African American AIDS Task Force in planning an AIDS awareness breakfast for leaders of the faith community, rather than merely watching others work and asking questions about the work.

In-depth Interviews

McCracken (1989) states that the long interview is "one of the most powerful methods in the qualitative armory" because it can "take us into the mental world of the individual, to glimpse the categories and logic by which he or she sees the world. It can also take us into the life-world of the individual, to see the content and pattern of daily experience." Morley (1988) notes that the long interview method provides access to the linguistic terms and categories or the logical scaffolding through which respondents construct their worlds and their own understanding of their activities. McCracken notes that the long interview allows the researcher to "accomplish certain ethnographic

objectives without committing the investigator to intimate, repeated, and prolonged involvement in the life and community of the respondent."

Semi-structured, ethnographic interviews were conducted with 12 key informants from two African American churches and two AIDS organizations. The questions were developed to encourage clergy and informants from churches and AIDS organizations to provide detailed explanations illuminating their activities, opinions, knowledge, language, and logic (Appendices A-1 & A-2). While the list was flexible enough to allow respondents to freely and openly present their views, their responses were useful in constructing the context in which the individuals thought and talked about AIDS.

These interviews were administered individually and followed a standardized format in terms of the goals of the interview, the general questions utilized, and informed consent procedures. However, the questions were phrased in a general and non-directive manner and often were based on topics grounded in participant observation. In addition, the questions were supplemented by floating prompts, including the investigator's repetition of a key term from the informant's response or her asking, "What do you mean by. . . ?" Planned prompts asked informants to contrast, categorize, or recall examples of topics or incidences. The sequence in which the questions are asked is determined by the informant's responses (McCracken, 1988, pp. 34-37).

The in-depth interview protocols contained both grand tour and logistical questions, was open-ended and improvisational in tone, and was developed with the intent of sustaining the flow of conversation and following the nuances of the moment.

Prompts were sometimes used, within the context of the dialogue, to gather additional information or opinions about particular topics.

The AIDS-related questions were designed to uncover what AIDS means to the individual, the individual's experience with or knowledge of AIDS and people living with AIDS, sources of AIDS information, and existing knowledge and beliefs about AIDS. The respondents also were asked to talk about and evaluate any previous conversations they have had about AIDS. Several questions asked participants to define and explain personal limits regarding the kinds of AIDS education efforts they might consider acceptable within their churches, and the specific contexts in which AIDS dialogue would be permissible.

The interviews were tape recorded, and when possible, recorded in hand-written field notes during the conversations. The respondents determined the location and scheduling of the interviews. When possible, interviews were conducted in non-academic settings. Interview locations included business and church offices, restaurants, an outdoor church fair, and homes. Interview length depended on the informant's interest, communication style, and competing time commitments, with the shortest interview taking 30 minutes, and the longest interviews taking more than two hours. Most interviews lasted about one and one-half hours.

The long interview was more appropriate for this study than participant observation alone because far more field time would have been required to observe any AIDS-related discussions that might arise within the African American churches, given that none of the churches were significantly involved in these discussions at the

beginning of the study. In keeping with ethnographic methodology, the operationalization of the key concept, HIV dialogue within African American churches, and the categories of analysis were allowed to arise from the data collected. The broad, logistical purposes of the long interviews, based on aims suggested by Lazarsfeld (1944), included the following:

- To clarify the meanings of common opinions about the potential roles of the black church in AIDS prevention and to identify the factors that influence an individual to form these opinions.

- To classify complex attitude patterns and to distinguish among the decisive elements of expressed opinions, particularly as they relate to religiosity.

- To identify personal motivations behind the behaviors that comply or fail to comply with various AIDS prevention recommendations.

Recruitment of Key Informants

In developing community-based campaigns, qualitative methods are essential for uncovering both the roles of community activists as well as the roles of legitimizers and others who may be less directly involved in the more public aspects of dialogue (Nix, 1977). In this study, the in-depth interviews solicited views of community leaders such as ministers and AIDS organization members, while the focus groups and follow-up individual interviews solicited the views of adolescents and women from lower-income neighborhoods.

Portnoy, Anderson, and Eriksen (1989) argue that communication research too often focuses on the individual as the unit of analysis, while largely ignoring the importance of network relationships within the larger organization or social system. This

is often because the investigator assumes that because the individual is the unit of response, then the individual must also be the unit of analysis.

Given that descriptive ethnographic information does not represent a population in the quantitative sense, random sampling was not utilized. The goal of the ethnographic sampling was to establish the range of variation rather than the proportion of "typical" traits in a population. The work began with key informants, who are considered "experts" on the topic of interest. Subsequently, a network of participants was developed.

A combination of judgment and snowball sampling techniques were used, and both are non-random sampling techniques. The snowball sampling technique conceptualized by sociologists Palmore (1967) and Laumann (1973) was used to identify key informants in this study. This multistage approach asks the first round of informants to identify other informants, who then become respondents in the next phase of data collection. In using judgment sampling, participants were selected on the basis of characteristics considered relevant to the research questions, including ethnicity and organizational affiliation. As more information was gathered about the African American community, additional in-depth interviews and participant observations were conducted in order to maximize divergence of perspective and experience relevant to the research.

The interviews were designed to reveal the nature of social networks, as well as the concerns and inhibitions of community residents and their potential openness or

hostility to AIDS-related discussions. Informants were chosen for reasons outlined by
Lindlof (1995):

- They commanded respect from their peers.

- They could articulate their goals and opinions, as well as opinions of their
  peers.

- They expressed willingness to assist with the goals of this research proposal.

Nix and Seerley (1971) recommend at least 15 interviews be conducted, as a rule
of thumb, in cities of 10,000 to 100,000 population when using the community
reconnaissance method. McCracken (1989) argues that eight long interviews should be
sufficient for thorough representation of any given population, but emphasizes that
additional interviews should be conducted until the researcher is confident that the point
of information redundancy has been reached.

For the present study, 12 respondents were selected for long interviews. The chart
on the next page summarizes the key characteristics of these interviews. The sample was
comprised of the following clergy, AIDS organization members, and church members:

- Ministers from early-adopter churches in Gainesville:

  1. A female pastor from a large Pentecostal church.
  2. A male pastor from a small, conservative, nondenominational church.

- Leaders from the African American AIDS Task Force in Gainesville:

  3. The chairwoman of the organization.
  4. The co-chair of the organization.
  5. The head of the organization's faith community committee.

- Four church members:

  6. A female youth leader from a low-income neighborhood.
  7. A mother secretly living with AIDS.

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8. A teenage girl who serves as a youth leader.
9. A teenage girl who attends church regularly.

- Three leaders who helped launch HIV prevention programs in inner city African American churches in Washington, D.C.:

  10. The director of an AIDS ministry in a large Methodist church.
  11. The interim director of the U.S. Agency for HIV/AIDS and consultant for the National Minority AIDS Council.
  12. The official from the Agency for HIV/AIDS who serves as a liaison to the religious community.

Table 1 on the following page provides further details of the subjects of the in-depth interviews, including interview location, length, number of 1.5-spaced transcript pages generated, main topics of the interview, and a link to the appendix containing the protocol used for the interview.

The interview participant who did not exclusively fit into one of the key informant categories was a 37-year-old mother who had never publicly disclosed her HIV status (Appendix A-4). Her interview was included in the study because her testimony revealed direct and rare insights about stigma and coping with the disease in secrecy. In most research contexts, the only people known to be living with AIDS are those who have "gone public" and typically tell their personal testimonies to many large groups of people.

Because of the lack of isolation, speechmaking routines, and social support characteristic of their everyday lives, these individuals may not experience the same level of stigma, secrecy, and hopelessness as those who have not gone public.

Type	Affiliation or Identification	Sex	Location	Length, Date	# Pages of Transcripts	Main Topics	Protocol (Appendix)
AIDS org	AAATF chair	F	Her office	1.0 hrs, 4-12-95	4	Local HIV risks and prevention strategies	A-1
AIDS org	AAATF faith community committee chair	F	Restaurant	1.0 hrs, 4-12-95	6	Local churches' response to AIDS epidemic	A-1
AIDS org	AAATF co-chair	F	Restaurant	2.0 hrs, 6-12-97	12	Inroads for church AIDS prevention	A-1
AIDS org	U.S. Agency for HIV/AIDS (director)	F	Her office in DC	30 min, 8-10-95	2	Strategies/ideas for church AIDS-related events	A-1
AIDS org	U.S. Agency for HIV/AIDS (religious community liaison)	F	Her office in DC	30 min, 8-10-95	2	Barriers to AIDS dialogue in black churches	A-1
AIDS org	Mt. Calvary AIDS Ministry (director)	M	Church AIDS fair in DC	20 min, 8-12-95	2	History, goals, and challenges of his AIDS ministry	(none)
Church member	Mother living with AIDS	F	Church office	1.0 hr, 8-3-97	7	AIDS stigma, challenges, hope	A-4
Church member	Church youth leader & focus gr. member	F	Church office	30 min, 8-3-97	2	*Fotonovela* experiences	A-1
Clergy	Pastor (small, non-denom. church)	M	His office	1.5 hr, 9-26-96	9	Youth ministry, gay issues	A-2
Clergy	Pastor (large Pentecostal church)	F	Her office	2.0 hrs, 6-4-97	10	Inroads for church AIDS prevention	A-2
Church member	Teen & youth leader in small church	F	Her home	45 min, 7-4-97	5	*Fotonovela* evaluation	A-3
Church member	Teen who attended small church	F	Friend's house	45 min, 7-4-97	5	*Fotonovela* evaluation	A-3
Church member	Bible study leader	F	Her home	30 min, 1-13-98	3	Member check: follow-up interview	(none)
TOTAL	**13 individuals**	**11F, 2M**	**Eight different locations**	**12.3 hours**	**69 pages (8 tapes)**	**18 major topics**	**Four protocols**

TABLE 1: In-depth Interviews with African American Key Informants

The woman in the present study participated in one of the focus groups, without the other group members knowing that she had AIDS. She agreed to do an in-depth interview only after participating in the group session and negotiated the time and terms of the interview through her pastor, the only local person other than health care workers who knew that the woman had AIDS. She said she wanted to do a private interview because she could relate to stories shared by women who had a loved one die of AIDS and because "the Lord had everybody placed there for a purpose."

However, she said she was afraid to reveal her HIV status to the other women in the focus group:

> The one lady who was talking about her brother, I could relate to that. I could sit down and talk to her all day, 'cause she and I are on the same level. The lady that talked about the dying child, and the other lady in the corner who talked about her daughter, I could relate to that. I was sitting there relating to all those stories, but I couldn't talk like I wanted to.

The rationale for selecting African American ministers and community leaders for interviews was based on the positional-panel method of community reconnaissance (Nix, 1977), in which leader-respondents are selected on the basis of their formal authority in critical community sectors. This method was used by the Minnesota Heart Health Program (Bracht, 1988) not only to identify influentials but also to involve them directly in campaign planning to promote the eventual community ownership of the campaign.

The names and addresses of African American clergy from 53 churches in Gainesville and outlying areas within Alachua County were compiled from lists provided by the North Central Florida AIDS Network, the Gainesville Black-on-Black Crime Task Force, and by Florida Representative Cynthia Chestnut. These lists were used to assess

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the denominational diversity of the religious community and to develop key informant contacts, including ministers and female lay leaders, within several key churches. In evaluating the denominational diversity in Alachua County, about 40 percent are Missionary Baptist and other Baptist churches, 30 percent are Pentecostal, 7 percent are United Methodist, and 4 percent are American Methodist Episcopal (AME) churches.

Focus Groups

Focus group interviews have been used in health communication research to assess beliefs and attitudes, design materials and programs, and evaluate programs (Heimann-Ratain, 1985; Shepherd & Achterberg, 1992). The methodology also has been commonly used by advertising agencies and other marketing organizations to explore consumer attitudes about advertising and new product development. In social marketing, the technique typically involves one to two-hour, semi-structured interviews with small groups. The exchange of ideas and opinions in the focus groups can prove more valuable than opinions emerging through one-on-one interviews.

Focus groups provide a way of investigating issues by allowing participants to critique, comment, explain, and share their experiences, opinions, and attitudes. Interaction among participants generates discussions that provide a deeper understanding of issues (Krueger, 1994).

Focus groups alone cannot provide an adequate basis for assessing a population's educational needs and the best strategy toward reaching them with HIV prevention information. Rather, focus groups should be triangulated with other methods of inquiry such as long interviews, participant observation, surveys, experiments, or analysis of

population data. In addition, the most critical component of program development is an organization's ongoing experience in working with a target population (USCM, 1990).

Blacks Educating Blacks About Sexual Health Issues (BEBASHI) of Philadelphia, a community-based AIDS education organization, conducted teen focus groups to define commonly held beliefs about sexuality, AIDS, and relationship issues, then used this information to design pamphlets targeting black teens (Sanders, Egbuonu, & Hassan, 1988). The BEBASHI empowerment-based strategy was used as a model for focus group data collection in the present study.

The primary objectives for the focus groups conducted in this study were to use an AIDS prevention *fotonovela* as a springboard for discussions about actual and perceived barriers and inroads to HIV prevention within the church, to demonstrate how this tool can be used in discussing AIDS issues with youth, and to get feedback about how it might be improved for use as a full-scale intervention in the future. Specifically, the research domains for the focus groups included

- AIDS knowledge: transmission, black genocide theory, and sources of information about AIDS.
- AIDS attitudes: emotional responses, views of Magic Johnson, reactions to people living with AIDS, such as stigma and fear.
- Perceived susceptibility to AIDS: meta-perceptions about other black teens and whether they see the issue as "close to home."

- Trust and source credibility issues: Whom they talk to about sex or AIDS.

- Drug and alcohol use as AIDS risk factors and the extent that these behaviors are perceived as common among peers.

- Premarital sex and abstinence: views about what is real and what is realistic.

- Sexual scripting and social influence in hypothetical sexual situations.

- Religious dialogue about AIDS and sex, including views about AIDS talk in this context and the role of religion in their lives.

- Barriers and inroads to AIDS education efforts in the church.

- Knowledge and attitudes about AIDS and risk behaviors.

- Connections between religiosity and AIDS-related attitudes.

- Social contexts and settings relevant to the promotion of sexual abstinence.

- Personal relationships with youth and efforts to provide guidance.

- The role of church and church leaders in educating youth about AIDS.

- Perceptions of AIDS-related susceptibility, seriousness, and threat in the community.

- Effectiveness of using a *fotonovela* as an AIDS prevention tool targeting African-American youth.

The two churches that facilitated the focus group sessions had been identified as early adopters of AIDS dialogue in Gainesville's African American community. Ministers from these churches had attended at least one of the two annual Faith Community AIDS Awareness Forums sponsored by the African American AIDS Task

Force. The ministers' attendance at these events was considered evidence of their awareness, interest, and willingness to be publicly associated with potentially stigmatizing AIDS issues.

The focus groups were conducted in a church, a community center, and in a low-income housing project facility with African American youth in vacation Bible school and a summer community youth program, as well as African American women who were members of new Bible study group at a subsidized housing facility. Rather than use a single list of questions for multiple focus groups, the investigator developed five different protocols based on intervention-based goals for each of 10 focus groups in the study:

- Girls and boys pilot groups, in which participants discussed their AIDS knowledge, attitudes, and beliefs (Appendices B-7).

- First-round girls and boys groups. Topic: AIDS knowledge, attitudes, and beliefs (Appendices B-1 and B-2).

- Second-round girls and boys groups. Topic: *fotonovela* evaluation and strategies for disseminating the booklet among peers (Appendix B-3).

- Third-round girls and boys groups. Topic: The *fotonovela*-based conversations they had with friends and family members (Appendix B-4).

- First-round women's group. Topic: AIDS knowledge and beliefs, strategies for sharing the *fotonovela* with youth (Appendix B-5).

- Second-round women's group. Topic: *fotonovela* evaluation and the conversations they had with youth about this booklet (Appendix B-6).

The chart on the following page, Table 2, displays the composition, goals, and context of each focus group, and the subsequent discussion provides further methodological details about these groups.

In light of the totals reported at the bottom of the chart (Table 2), it is important to note that several teens and women participated in more than one focus group. A total of 14 women participated in a focus group, while a total of 20 youth participated in the two pilot study focus groups. It is not possible to determine the number of adolescents who participated in the other six focus groups because each child was required to bring a signed parental consent form only prior to the first time that he or she participated. Thus, most youths participated in three groups but were not identified by name after the first day because of a confidentiality agreement.

Pilot Study

The pilot study was conducted as part of a Vacation Bible School program in an African American, non-denominational church (Appendix B-7). Separate focus groups of 10 girls and 10 boys were interviewed about AIDS knowledge, attitudes, and beliefs by the investigator and a white male graduate student. In describing the nature of the church that served as the pilot study site, its pastor remarked:

> There are no rules about wearing hats or certain kinds of clothing. There's nothing that identifies us as different.

After the pilot focus group sessions, the youths participated in a pizza party and a two-hour, skit-writing workshop. During this workshop, the investigator asked the youths to volunteer ideas for various plots, scenarios, and AIDS prevention messages for original skits in an informal, classroom-style environment. The investigator listed these

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Time-line	Group Type	Sex	Age	Group Size	Length, Date	No. pages	Setting & Church Linkage	Session Objectives	Pro-tocol
Week 1	Pilot youth	F	10-17	10	1.0 hr, 6-17-97	8	Vacation Bible School (church)	HIV knowledge & attitudes + skit writing	B-7
Week 1	Pilot youth	M	10-16	10	1.0 hr, 6-17-97	8	Vacation Bible School (church)	HIV knowledge & attitudes + skit writing	B-7
Week 3	1st youth	F	10-16	11	1.0 hr, 6-30-97	13	After-school enrichment program at church	HIV knowledge & attitudes + skit writing	B-2
Week 3	1st youth	M	10-16	9	2.0 hrs 6-30-97	9	After-school enrichment program at church	HIV knowledge & attitudes + skit writing	B-1
Week 4	2nd youth	F	10-16	9	45 min, 7-7-97	12	After-school enrichment program at church	*Fotonovela* evaluations & IP strategies	B-3
Week 4	2nd youth	M	10-16	3	45 min, 7-7-97	8	After-school enrichment program at church	*Fotonovela* evaluations & IP strategies	B-3
Week 4	1st women	F	25-65	6	30 min, 7-10-97	5	Bible study in low-income apartments	HIV knowledge & attitudes, *fotonovela* strategies	B-5
Week 5	3rd youth	F	10-16	9	30 min, 7-10-97	37	After-school enrichment program at church	*Fotonovela* experiences, peer evaluations	B-4
Week 5	3rd youth	M	10-16	6	45 min, 7-10-97	5	After-school enrichment program at church	*Fotonovela* experiences, peer evaluations	B-4
Week 7	2nd women	F	25-55	12	1.5 hrs, 7-24-97	33	Bible study in low-income apartments	*Fotonovela* evaluations & experiences	B-6
TOT	**10 groups**	**4M 6F**		**85 = 57F + 28M**	**11.3 hours**	**138 pp.**	**3 different locations**	**8 session objectives**	**9**

TABLE 2: Focus Groups of African American Adolescents and Women

ideas on a large paper pad and gave the youths a skit-writing handout (Appendix C-1)

designed to help them develop characters, setting, scenario, conversation, and important

factual information to include in their scripts.

After the group discussion, pairs and small groups of youths collaboratively brainstormed and jotted down their scripts using neon-colored pens and pastel-colored legal pads. The youth were permitted to write and discuss anything they wished. Although several adults supervised the workshop, the youths were not told to use any particular formula or theme.

After 45 minutes of collaborative writing, the youths were given the chance to perform their skits and raps for the entire group. An "AIDS Peer Education Award" certificate was presented to every skit workshop participant during a worship service the following Sunday. In addition, yogurt shop gift certificates were awarded to authors of the first-place skit.

An analysis of transcripts from the pilot focus groups and field notes from the skit workshop helped refine the protocols, moderator training guidelines, and skit workshop procedures for the *fotonovela*-intervention youth focus group sessions.

Youth Focus Groups

The focus groups for youth and women served a dual purpose in this study: (1) to enable participants to develop, distribute, and evaluate a *fotonovela* targeting youth with AIDS prevention advice, and (2) to explore attitudes, beliefs, and perceptions of others' behaviors through semi-structured interview protocols and through discussion of the *fotonovela* at every stage of its development and testing. Figure 16 is a comparison chart of all focus groups.

Within the setting of an after-school summer enrichment program sponsored by another Pentecostal African American church, three rounds of focus groups were

conducted with boys and girls during a three-week period. The participants were separated into girls and boys focus groups. The average age of the adolescents was 13, while their ages ranged from 10 to 16. A 16-year-old African American girl was trained to moderate the three girls' groups, while a 20-year-old African American man was trained to moderate the boys' groups.

The first round of focus groups, with 9 boys and 11 girls in the summer enrichment program, required 1½ hours. The protocols for these groups (Appendices B-1 and B-2) were designed to obtain a baseline assessment of knowledge, attitudes, and beliefs about AIDS and sexuality, as well as views of AIDS-related dialogue in various contexts.

The session began with the showing of "On the Pillow," a dramatic video about an African American teenage boy who becomes HIV infected and seeks comfort from his minister (Appendix C-6). The 9-minute video was produced, written, directed, and photographed by Parrish Smith, a former graduate student at Howard University Divinity School (Smith, 1995). The 1995 film tells the story of Terrence, who becomes drunk with his friends, goes home with a beautiful stranger named Crystal, and discovers a note from her the next morning welcoming him to the world of AIDS. After testing positive for HIV, Terrence confides in his minister, the Rev. Barnes, that he has probably infected his pregnant fiancée, Alicia.

The focus group moderators encouraged participants to comment on issues presented in the video, including issues of AIDS awareness, abstinence, risky behaviors, and communication with adults about dating relationships.

After the first-round focus group sessions ended, all youths participated in a pizza party and a two-hour workshop in which they wrote and performed skits and raps about AIDS. At the end of the summer, an "AIDS Peer Education Award" certificate (Appendix C-5) was presented to every focus group participant during an awards ceremony.

The second round of focus groups, in which 3 boys and 9 girls participated, was conducted one week after the first round. The second round protocol (Appendix B-3) was designed to solicit feedback about the *fotonovela* and to elicit strategies for using the booklets as a peer education tool.

The third round of focus groups, in which 6 boys and 9 girls participated, was conducted a week after the second. This final group protocol (Appendix B-4) asked youth to talk about their experiences in sharing the booklet, as well as their peers' evaluations and reactions. In addition to asking participants to assess the nature and tone of these real-life conversations, they were asked to discuss strategies and preferred settings for future conversations. If any individual participated in the third session but not the second, he or she was asked to provide an evaluation of the *fotonovela* itself rather than personal experiences in using it.

Women's Focus Groups

Given that ties between women constitute the core of the social network within the African American community (Stack, 1974), women were recruited to serve as opinion leaders for disseminating an AIDS prevention *fotonovela* to youth.

The moderators for the women's groups were two African American women: a church leader interested in AIDS ministry, and an African American AIDS Task Force member who also was a registered nurse and trained AIDS educator.

Two women's focus group sessions were conducted during a two-week period that was concurrent with the youth focus group schedule. The women in both focus groups met at a subsidized apartment complex, in a small brick clubhouse furnished with folding metal chairs and tables, a television, and kitchenette.

A female pastor recruited participants for both women's focus groups by asking church members to recruit friends to attend a "special AIDS program" that would launch a new weekly Bible study group in the apartment complex. The ages of the women recruited for the focus groups ranged from early 20s to late 60s, while most were in their early to mid-30s.

During the first women's group (Appendix B-5), the six participants watched the "On the Pillow" video, received copies of the *fotonovela* (Appendix D), and discussed strategies for sharing the booklets with youth. Three informative handouts were provided to stimulate this discussion: "Tips for Using the Story Booklet," (Appendix C-2), "How to Break the Ice" (Appendix C-3), and "How to Talk to Kids about Sex" (Appendix C-4). Overall, each woman was encouraged to endorse the positive value and benefits of sexual abstinence, to avoid a "preachy" tone (i.e., "You should not…"), to use herself as an example in conversations whenever possible (i.e., "I had a similar experience when I was your age…"), and to explain why she is sharing the *fotonovela*.

During the second women's group (Appendix B-6), the 12 participants were asked to evaluate the *fotonovela* and discuss their experiences in sharing the booklets with youth.

Moderator Training and Protocol Development

Each of the six focus group protocols (Appendices B-1 through B-6) was a comprehensive list of questions designed to address certain topics and meet specific objectives. The protocols included a moderator's guide to help ensure compliance with research procedures and to serve as an aid in conducting the focus groups.

Four focus group moderators were trained to explain objectives and ground rules for their sessions. In an effort to promote an open and non-threatening atmosphere and to help participants better articulate their feelings, the investigator trained moderators to use transitions and prompts, to mirror participants' comments, and to provide summaries of topical discussions.

The moderators also were instructed to refrain from personally responding to the questions or from making other comments not included in the protocol, except to re-phrase a question or to recap a discussion. Although some participants displayed disruptive behavior or talked at length about topics unrelated to study goals, neither the investigator nor the moderators displayed disapproval during data collection. In addition, the tasks of discipline and controlling the discussion were left to the moderators.

Moderators were encouraged to help respondents feel relaxed, to manage group dynamics in such a way that the greatest number of people could participate, and to ask questions in a tone that does not bias the answers.

For each focus group session, the questions were listed by topic within a detailed protocol that included introductory statements, open-ended questions written in a non-threatening tone and first-person voice, transitional statements, and a checklist of topics at the end. Some questions asked participants to think about hypothetical situations, while others were designed to elicit meta-perceptions. In general, the questions that asked participants to voice potentially embarrassing personal views were listed after the questions that asked them to speculate about the views of their peers.

The focus group questions were based on the research objectives, concepts from the theoretical framework, and issues discussed in previous in-depth interviews and during the pilot focus group study. Questions were designed to allow the respondents to follow their own thought processes. Some questions were rephrased or otherwise clarified after moderators offered suggestions during training about items that they found to be confusing.

Fotonovela Development

Adolescents aged 10 to 16 were the target of the *fotonovela* demonstration. Youth in this age group, as well as women aged 18 and older, were the key opinion leaders selected for dissemination of the *fotonovela* to targeted youth. About 20 youth participating in the summer program, as well as 6-8 youth involved in the pilot group, contributed skit scripts that were synthesized into a single *fotonovela* script. The youths wrote these scripts as part of an AIDS skit workshop, described earlier in this chapter.

Excerpts from the youth-written skits, as well as ideas obtained through one-on-one conversations and observed behaviors, were combined to produce a story line and

script. This narrative was intended to portray everyday situations experienced by African American teens in this age group, using slang and other colloquialisms popular among the youth. The names of characters were borrowed from various youth-written skits. The *fotonovela* narrative depicted African American youth discussing HIV-related issues in an abstinence-based context.

The *fotonovela* was pretested before it was published for distribution to focus group participants. Pretesting AIDS prevention materials is "a systematic process of testing target audience reactions to specific messages, vocabulary, visuals, sequences, and materials before they are produced in final form," and it "allows programmers to determine if materials are clear, persuasive, attractive, and seen as relevant among a particular audience" (Smith & Debus, 1992, p. 68).

A draft of the *fotonovela* script, including the story, raps, and AIDS facts, was reviewed and critiqued by two 16-year-old girls who were not focus group participants. The girls both attended a small, conservative church other than the one sponsoring the summer youth program, and one girl was a church youth leader. The pretest was conducted prior to the photo sessions because the evaluators' recommended changes in the script required a revision of the planned storyboard as well. The girls' opinions were solicited during a one-hour, taped discussion session at the home of one of the evaluators (Appendix A-3).

As suggested by Krueger (1994) and Meade & Smith (1991), the girls evaluated the script on such criteria as learnability, reading ease, organization of information, legibility, motivation or interest in the material, cultural appropriateness, the amount of

time required to read the material, and possible effects of a reader's experiential history and prior knowledge. This feedback was used to edit and refine the *fotonovela*, such that it could be written at a 6th grade reading level.

After the final revision of the *fotonovela* script was finished, 15 members of the summer youth program were photographed for the illustrations needed to coordinate with the script and raps. Using a 35-mm zoom-lens camera, the investigator took posed photographs of youth acting out each scene of the skit. In addition, candid photos were taken of various everyday, non-staged youth activities such as boys playing basketball in the parking lot and girls practicing their step show on the sidewalk.

Out of 85 color photos taken, 20 were selected for use in the *fotonovela*. These photos were scanned in grayscale and paired with the script, using Microsoft Word software, in order to assemble the final booklet. More than 300 copies of the *fotonovela* were individually printed in black-and-white on an inkjet printer, and each booklet was hand-folded. The *fotonovela* could not be effectively photocopied because the gray tones were eliminated, regardless of the photocopier quality or settings. (For future *fotonovela* interventions, it is recommended that the booklets be printed in bulk using an offset printing process to minimize the time and expense of hand-printing and folding.)

A *fotonovela* "kit" for focus group participants consisted of a business-sized envelope containing 5 to 10 booklets and a small log sheet where the focus group participant could record the names of those with whom they shared the booklets.

The moderators distributed the kits to the focus groups, after asking each participant to think of four individuals with whom he or she intended to share the *fotonovela* before the follow-up focus group session.

Fotonovela Content

The *fotonovela* used in this study was a short, illustrated drama presented in a trifold, legal-size brochure format (Appendix D). Although the traditional *fotonovela* format used in Hispanic communities is typically much longer, at least 10 pages in length, prior research shows that a shorter format may be more culturally appropriate for African-American audiences (Gromley, 1996). In a study of HIV sexual risk reduction interventions for African American women, DiClemente and Wingood (1995) found that a brief, social skills-based and contextually relevant educational intervention can have more value than a longer but less-tailored HIV education intervention. Similarly, the BEBASHI program described earlier in this chapter encouraged African American teens to contemplate the challenge of standing up against peer pressure in their community (Sanders, 1988).

The primary objectives of the *fotonovela* in the present study were

- To educate African American women and youth, including low-literacy individuals, about abstinence-based AIDS prevention.
- To encourage them to ask more questions and seek more information.
- To encourage them to initiate dialogue and offer social support in discussing AIDS-related issues.
- To take preventive measures to slow the spread of AIDS.

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In developing an AIDS prevention video message, Maibach (1989) found that those who model the behaviors should be similar to the audience in gender, age, race, and attitudes, and behavior strategies should be demonstrated in settings similar to those that the audience will encounter.

The *fotonovela* script attempted to incorporate elements of humor, drama, and romance, as well as the consequences of AIDS. The skit highlighted who is vulnerable and why, promoted personal control in AIDS prevention, provided information about HIV transmission, showed that the AIDS threat is local and close, and demonstrated strategies for interpersonal communication about AIDS.

Intended Outcomes

This study explored how various predisposing and environmental factors informed the design and delivery of a *fotonovela* targeting African American youth, how cognitive and normative processes affected their involvement in the intervention, and how culturally specific barriers and enabling factors mediated their attitudinal and behavioral responses to the *fotonovela*. The intended outcomes of the *fotonovela* intervention included:

- Open dialogue about AIDS prevention, between and among adolescents and adults.
- Verbal expressions of interest in AIDS issues.
- Greater individual awareness and knowledge about AIDS-related behavioral risks.
- Changes in social norms within church-based networks, including the initiation of AIDS prevention dialogue by opinion leaders.

- Sexual abstinence or the postponement of further sexual involvement.

- Open but sensitive dialogue about condoms, in a manner and context that is acceptable among religious individuals.

Consistent with the goals of communication network research, as described by Rogers and Kincaid (1980), the present study attempted to identify communication roles as well as connectedness between individuals and within personal networks. These roles were assessed by examining the number of youth who received *fotonovelas* from focus group participants, the criteria that participants used to select these young people, the nature of social relationships between the participants and the youth they targeted, and the settings where the youth were contacted.

Readability Analysis

Readability is commonly defined as "interesting to read" or "capable of being read easily." A readability formula is a mathematical equation that estimates the number of years of education needed to easily understand a selection of text (Hitchner, 1991).

Most HIV educational materials developed for use by injecting drug users is written at a reading level several grades above that of the target audience (Johnson, Mailloux, & Fisher, 1996). Readability formulas are a desirable tool for evaluating AIDS prevention materials because of their long-standing use in school settings, their half-century reputation for methodological accuracy for categorizing reading materials by grade level, and reported internal consistency within and between various formulas when determining reading levels (Meade & Smith, 1991).

Readability formulas are intended to be used as an evaluation tool for revision of a completed text, not as a tool for writing a text (McClure, 1987). Given that the targeted readers of the *fotonovela* were in middle school (6th and 7th grades), a desirable readability score for this study would be 6th grade or lower. Similarly, Davis (1989) used language appropriate for readers at the 5th grade reading level, corresponding to the average Gunning Fog Index score of articles in popular magazines, in designing an instructional pamphlet for condom displays in pharmacies. To ensure that the *fotonovela* scripts could be comprehended by the average African American reader aged 12 or older, readability scores were computed for each revision of the *fotonovela* until a score was achieved that corresponded to a 6th grade reading level.

The Gunning Fog Index, the most widely used and documented readability formula (Wells & Spinks, 1991), was used to compute these scores. This formula, unlike others, is designed to measure levels of comprehension rather than levels of speaking (Gross & Sadowski, 1985). Davis (1994) argues that the Fog Index is more stringent, and thus tends to compute higher-grade levels for texts than other readability formulas.

Robert Gunning (1968) used the word "fog" because he felt that most writings were clouded and muddled – only after the "fog" settled could the true meaning of a writing be revealed and understood (Spinks & Wells, 1993). The Fog Index reading grade level is computed by multiplying 0.4 by the sum of the average number of words per sentence and the percentage of words containing three or more syllables. Word length is associated with precise vocabulary, which means a reader must exert extra effort to identify the meaning of words containing more than one syllable. Long sentences

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typically have complex grammatical structure and thus require readers to remember several parts of the sentence before they can combine the parts into a meaningful whole (McLaughlin, 1969).

The SMOG Grading formula developed by Fry (1968) is considered to be more valid than other readability formulas, including the Flesch Reading Ease, Dale-Chall, Spache, and Wheeler & Smith formulas, as well as the Cloze procedure and the McCall-Crabbs Test Lessons in Reading (Meade & Smith, 1991; McLaughlin,1969). However, the SMOG formula does not compute a readability score below sixth grade and thus is not usable in this study. Olson (1986) reported a correlation coefficient of R=.67 between the SMOG formula and Fog Index, the highest correlation of any pair of six different readability formulas.

Thus, for reasons of optimal validity and logistics, the Fog Index was considered the most appropriate formula for evaluation of the *fotonovela's* readability. Beyond assessment of semantic and syntactic complexity using Fog Index score calculations, the overall readability of the *fotonovela* was evaluated using feedback from youth informants.

The Fog Index also was used to assess the readability of the informed consent and youth assent forms. These calculations showed that the women's focus group form was written at a 10th grade level, while the parental consent form was written at a 13th grade level (high school graduate) and the youth assent form was written at a 6th grade level.

This procedure was considered essential in light of Priestly et al's (1992) study which showed that 96 percent of consent forms for research on adults were more difficult to read than an average newspaper article, which is typically written at a 13th grade level. Similarly, Goldstein (1996) found that the average reading level of university-sponsored consent forms was 12th grade, and less than 10 percent of the forms were written at a 10th grade level or below.

Informed Consent

Participants were required to express a willingness to articulate their opinions and to assist with the goals of this study and were given the opportunity to opt out of the discussion.

All participants in the in-depth interviews were asked to sign a consent form (Appendix F-1). A standard form also was used for participants in the adult women's focus groups (Appendix F-2). A youth assent form (Appendix F-4) was read to youth focus group participants at the beginning of each session. Each child was required to bring a signed parental consent form (Appendix F-3), and children who did not present this form were not interviewed or photographed.

Transcripts from the in-depth interviews and focus groups were not shown to others, in compliance with confidentiality restrictions of the informed consent agreement. The interviews did not pose physical, economic, nor psychological harm to any participant, although participants may have benefited by gaining new understanding about AIDS risks and about what they could do personally to help slow the spread of the disease in their community. Although a few participants may have considered certain

topics to be controversial, no question probed into personal sexual behaviors or other issues that might be considered personally embarrassing. Preliminary conversations with African American leaders suggested that controversial themes might include condom use, drug abuse, homosexuality, promiscuity, stigmatization of people with AIDS, and genocide beliefs.

Focus group moderators were paid $10 an hour for their assistance, while focus group and in-depth interview participants were not compensated. Funding for the moderator stipends was provided by a Graduate Student Research Award grant from the University of Florida College of Journalism & Communications.

Data Analysis Procedures

Focus group interview data was compared with individual interview data to show patterns in the influence of peer norms on individual attitudes, values, and beliefs about AIDS prevention. Direct quotes from participants were included to provide a feel for the narratives, and paraphrases also were used to help contextualize many remarks.

The data analysis generally was driven by the research question, "What are the inroads and barriers to AIDS dialogue within social networks among African Americans?" Given that the themes were organized using a theoretical framework, the contexts of participant comments and observations were identified using only simple labels that identified the gender (male or female), age (youth or adult), and type of interview (focus group or long interview). This data analysis strategy permitted conceptual, rather than contextual, comparisons and interpretations of various narratives.

In analyzing the transcripts and field notes from participant observations, long interviews, and focus groups, the investigator subdivided these data-texts into small "chunks" (each comprised of a word, phrase, sentence, or paragraph) and then assigned a descriptive, interpretive, or pattern-oriented label to each chunk. From an initial list of 246 labels (Appendix E), a coding scheme was developed that synthesized conceptual tags ranging from micro to macro levels. In general, the resulting themes accounted for settings/contexts, definitions of situations and topics, perspectives, ways of thinking about people and things, processes, activities, events, strategies, relationships, and social structures.

The exploratory research design elicited data from a wide variety of settings and sources, using a sequential and iterative methodology. This approach created a data set comprised of far more topics and perspectives than likely would have been accumulated through the traditional method of using one protocol for all individuals or groups. Thus, a major challenge in analyzing this data was to find a way to effectively organize the vast array of concepts while logically and systematically modifying the existing theories that predict the prevention of AIDS risk behaviors. This was accomplished by contextualizing the emerging themes and interpretations within the conceptual framework and by using verbatim excerpts from the transcripts to illustrate these themes.

Theme analysis was conducted through scanning all data-texts for commonalties and differences, comparing incidents applicable to emerging categories, and integrating categories and their properties. The categories and terminology were eventually delimited to achieve parsimony and scope, at the point where the category set became

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theoretically saturated and new incidents added little, if any, new value to its conceptual content.

The theoretical model described in Chapter 2 was used as an organizing framework for various sections of theme analyses of the data-texts. Both the framework and theme analysis of various texts included and interpreted data-texts from focus groups, interviews, and participant observation.

This approach has been advocated by Miles and Huberman (1994), who note that an increasing number of qualitative researchers are using pre-designed conceptual frameworks and pre-structured instrumentation (p. 20). The use of theoretical frameworks are particularly useful for data analysis in large-scale qualitative studies, given that "text is an unwieldy display device and that therefore better displays are a major vehicle for valid and reliable research" (Henwood & Pidgeon, 1994, p. 230).

While the use of general, over-arching themes is an effective strategy for qualitative data analysis in certain situations, the use of a theoretical framework as a data analysis tool was a more appropriate approach in this study. The model was conceptualized using existing theory and evidence, and subsequently it was re-evaluated in light of new data.

The theoretical framework based on existing literature, presented in Chapter 2, subsequently was modified in Chapters 4 and 5 through the examination of data-texts in light of various constructs. Thus, the theoretical model was used to illuminate comparative observations and other facets of the data. This approach is justified by the assumption that useful, existing theory

Illuminates what you are seeing in your research. It draws your attention to particular events or phenomena and sheds light on relationships that might otherwise go unnoticed or be misunderstood. (Maxwell, 1996, p. 33)

Maxwell (1996) asserts that some categories may be drawn from existing theory, while other categories may be developed inductively by the researcher during analysis or taken from the conceptual structure of the people studied. This dual strategy was used in developing the categorization scheme. Miles and Huberman (1994) explain:

Categories such as 'social climate,' 'cultural scene,' and 'role conflict' are the labels we put on intellectual 'bins' containing many discrete events and behaviors. No researcher, no matter how inductive in approach, knows which bins are likely to be in play in the study and what is likely to be in them. Bins come from theory and experience and (often) from the general objectives of the study envisioned. Setting out bins, naming them, and getting clearer about their interrelationships lead you to a conceptual framework. . . . Having to get the entire framework on a single page obliges you to specify the bins that hold the discrete phenomena, to map likely relationships, to divide variables that are conceptually or functionally distinct, and to work with all of the information at once. (p. 18, 22)

Similarly, Maxwell proposes a "theory as coat closet" metaphor to illustrate how a framework that synthesizes existing theory can be used for qualitative data analysis:

A useful, high-level theory gives you a framework for making sense of what you see, particular pieces of data that otherwise might seem unconnected or irrelevant to one another or to your research questions can be related by fitting them into the theory. The concepts of the existing theory are the 'coat hooks' in the closet; they provide places to 'hang' data, showing their relationship to one another. (p. 33)

The use of existing theoretical concepts as coding categories also is an accepted practice in qualitative research. For example, Gilgun (1994) argued that "previous research and theory also provide concepts and hypotheses that can be used to organize data" (p. 119). In the present study, the theoretical framework was the conceptual basis

for the analysis, but the findings were inductively derived and intended to reflect the perspective of the informants.

Maxwell (1996) argues that qualitative researchers fail to make good use of theory when they fail to "explicitly apply or develop any analytic abstractions or theoretical framework for the study, thus missing the insights that only theory can provide" (p. 36). Using concepts from prior theory is as valid as concocting interpretive categories from the data, because as Henwood and Pidgeon (1994) argue, "Philosophically speaking, theory cannot simply emerge from data. Observation is always set within pre-existing concepts, and this raises the question of what grounds grounded theory?" (p. 232). Miles and Huberman (1994) point out that a conceptual framework serves to specify "who and what will and will not be studied" and it illuminates some relationships among concepts.

Throughout Chapter 4, the theoretical model was used as an organizing framework, not as a theory in itself to be "proven." The study was constructed and conceptualized such that the model was used as an organizing and framing device for the data. Themes were developed within the various categories, using the topics and language of the research participants. For example, six themes illuminated dimensions of individual religiosity (i.e., "Reading the Word," "The 'Inner Spirit,'" The Life 'Out There,'" "The 'Slip Up'"), and examples and discussion of each of these particular themes were presented within the *Predisposing Factors* domain because those themes and corresponding examples logically could be discussed under the broad concept of religiosity as a psychographic variable in this particular context of the analysis. Other

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facets of religiosity were discussed elsewhere in the chapter, such as "pastoral norms" and "church influence" within the *Normative Processes* domain; "compassion" and "reinforcement of religious values" within the *Enabling Factors* domain; and the "just world belief," "church as protection," "church politics," "religious taboos," "expectation for divine healing," and "church stigma" themes within the *Barriers* domain.

The eight theoretical domains used to organize themes were used as "intellectual bins," without which the investigator likely would have overlooked many important distinctions and subtle dimensions of the various factors that influence AIDS preventive behaviors among African Americans. Without such an organizing framework, the data analysis would have been oversimplified, and a web of important theoretical distinctions would have been lost that eventually facilitated the modification of existing theory. Most themes and sub-categories that emerged from the data, described within each of the eight domains, were different from the sub-categories that emerged from the existing literature.

Some properties within the domains are variables or other sub-categories of major theories, while others are broad individual factors, such as religiosity, that are used as headings to logically group together related themes that emerged from the data. Strauss and Corbin (1990) recommended that categories be dimensionalized by separating out their different properties. Similarly, Maxwell (1996) advised that

> An initial framework often works best with large categories that hold a lot of things you haven't yet sorted out. However, you should try to differentiate these categories, making explicit your ideas about the relationships among the things in them. One way to start this is by analyzing each one into subcategories and identifying the different kinds of things that go into each. (p. 32).

While the intent of the study was not to "prove" the validity of the theoretical framework, a key purpose of this study was to critically examine the constructs of existing health communication theory through the cultural lens of the African American community. This analysis was conducted in order to discover how various theoretical concepts ought to be modified in order to develop a more culturally appropriate AIDS prevention model.

The use of the theoretical framework facilitated the addition of new dimensions to existing theoretical models such as the Health Belief Model and Theory of Reasoned Action, and in turn, these cultural insights helped explain health behavior patterns among African Americans. Villarruel and Denyes (1997) argue that in studying diverse ethnic populations, "conducting theory-testing research is necessary to establish, verify, or refute the link between theoretical concepts and unique realities" (p. 283). Maxwell (1996) also supported this approach:

> A review of relevant prior research can be a source of data that can be used to test or modify your theories. You can see if existing theory is supported or challenged by previous studies. Finally, you can use prior research to help you generate theory (p. 43).

Similarly, Silva and Sorrel (1992) indicate that by using inductive theory testing strategies, generalities that constitute the substance of theory can be identified. Mays and Pope (1995) argue that if the findings "diverge from those predicted by a previously stated theory, they can be useful in revising the existing theory in order to increase its reliability and validity" (p. 111). Panitz (1997) argues that it is not sufficient for changes to existing theory to be only "purely conceptual, suggesting further research" (p. 170).

Given that the theoretical model was used as an organizing framework for data analysis, the presentation of findings in Chapter 4 included discussion of theoretical linkages. In their critique of the standards of rigor in qualitative research, Mays and Pope (1995) support this approach:

> It is not normally appropriate to write up qualitative research in the conventional format of the scientific paper, with a rigid distinction between the results and discussion sections of the account. It is important that the presentation of the research allows the reader as far as possible to distinguish the data, the analytic framework used, and the interpretation (p. 114).

Gilgun (1994) notes that many qualitative researchers "seek to link findings to previous research and theory" (p. 117), and Howe and Eisenhart (1990) assert that qualitative researchers must provide a "useful balancing of present research with broader bases from other bodies of knowledge" (p. 2). Further, Silva and Sorrel (1992) state that a major criterion of qualitative theory testing is that "findings are discussed in terms of how they relate to existing theory" (p. 12).

The theoretical framing of data in Chapter 4 also is defensible by methodological standards of qualitative research. In dealing with the "sheer volume of data customarily available," Mays and Pope (1995) argue, a researcher should "present extensive sequences from the original data, followed by a detailed commentary." They further argue that a standard of rigor in qualitative research is that the researcher must "make explicit in the account the theoretical framework at every stage of the research" (p. 114). In addition, Gilgun (1994) asserts that framing findings with previous research, theory, and "practice wisdom" can enhance practitioner utilization of the research findings (p. 123).

Maxwell (1996) further recommends that the conceptual framework serve to present the data analysis "in a form that allows it to be grasped as a whole" (p. 80). Similarly, Miles and Huberman (1994) argue that flowcharts or figures representing causal networks are particularly useful for "analysis of a wide range of problems and settings" (p. 11).

Many previous qualitative studies (i.e., Hirschman & Thompson, 1997; Contractor & Eherlich, 1993; Villarruel & Denyes, 1997) have used a framework of existing theory as a data analysis tool. In their study of consumers' relationships with advertising and mass media, Hirshman and Thompson (1997) drew upon theories from several different disciplines to develop an analytical framework that included concepts of ideological structures, cultural frames, active readership, production of meaning, and consumer socialization. These constructs were used to frame research questions and to identify interpretive strategies that consumers use to form relationships with the mass media. The authors explained that "concepts and findings from relevant prior research are used to provide context for our discussion and a theoretical web for the results" (p. 47).

Threats to Validity

Qualitative research has its own set of standards of quality and rigor. In describing the potential roles of qualitative research in AIDS prevention, Smith and Debus (1992) assert that

> Not every casual conversation is an 'in-depth interview,' not every group meeting is a 'focus group,' and not every neighborhood visit is an 'ethnographic study.' (p. 70)

While a number of quality checks can help ensure that qualitative research is carried out rigorously, it is important to evaluate and weigh each recommendation in light of the particular objectives of a study rather than to indiscriminately apply some textbook "recipe." Maxwell (1996) warns that

> Ultimately the identification of plausible validity threats requires a creative and open-minded approach, rather than simply going through a pre-established checklist such as that given by Campbell and Stanley (1963). (p. 93)

The following list offers remedies to common threats to validity in qualitative research, and each recommendation is discussed in light of the research design of the present study.

1. *Use verbatim transcripts* of audio/video recordings of interviews. Smith and Debus (1992) recommend that a data analysis description include quotes from participants as well as paraphrased remarks because this data "permits the planner to get a direct feel for the data" (p. 70).

    A related threat to valid description is the inaccuracy or incompleteness of the data. In the present study, tape-recorded discussion during all in-depth and focus group interviews was transcribed verbatim, including the participants' use of slang, improper grammar, rambling, and colloquialisms. Each transcription was verified against the tapes. In addition, the investigator did not rely on memory, impressions, or hand-written notes except in conducting participant observation.

2. *Use member checks.* According to Guba and Lincoln (1989), obtaining member checks involves systematically soliciting feedback about one's data and

conclusions from the people being studied. While the participants'

pronouncements are not necessarily valid, their responses are taken simply as

evidence that the researcher's account is valid (Hammersley & Atkinson, 1983).

In the present study, numerous informal member checks, including a more

structured member review of findings, were conducted throughout the data

collection and analysis phases of the research.

3. *Use open-ended questions.* Asking leading, closed, or short-answer questions

does not give participants the opportunity to reveal their own perspective. Most

questions in the in-depth and focus group protocols were open questions, and

group moderators were trained to use question prompts to further encourage

participants to elaborate. Stewart (1990) explained that closed questions elicit

brief answers like yes or no or maybe, whereas open questions "invite long,

unrushed, rambling answers." He also noted:

> Leisurely open questions get to the heart of things faster than those fast-
> paced, closed inquiries. Using open and closed questions with some
> awareness is basic to effective information gathering. . . . Learning and
> using (these talk tools) as adults won't guarantee results, but getting
> accustomed to using the right tool can make stunning improvements in
> effective information gathering. (p. 72)

4. *Triangulation.* Patton (1989) argues that triangulation of data sources, theories,

investigators, and/or data collection methods can help remedy threats to validity

caused by the subjectivity of interpretation. In this study, all four of these types of

triangulation were used to improve the validity of the research results.

Patton (1989) states that investigator triangulation is "the use of one or

more researchers or evaluators." Further, investigator triangulation is not limited

to the use of multiple coders. Flynn et al (1991) argue that investigator triangulation can take the form of multiple observers who participate in data collection. In the present study, four focus group moderators not only assisted in data collection but also offered their own insights about their observations.

Given the type of data analysis needed to expand and modify existing theory, the author of this study was the sole coder of the data-texts. The use of only one coder is acceptable practice in qualitative research. In describing basic steps of qualitative data analysis, Kvale (1996) notes that "the transcribed interview is interpreted by the interviewer, either alone or with other researchers" (p. 189) and "the analysis of interviews is often undertaken by the researcher alone" (p. 208).

Maxwell (1996) argues that qualitative research "is not primarily concerned with eliminating variance between researchers in the values and expectations they bring to the study, but with understanding how a particular researcher's values influence the conduct and conclusions of the study" (p. 91). Kvale (1996) suggests the use of multiple interpreters as one way of controlling analysis, but in the same discussion, she states:

> An alternative to a multiple interpreter control of analysis is that the researcher present examples of the material used for the interpretations and explicitly outline the different steps of the analysis process. (p. 209)

5. *Use rich data.* "Rich" means that data is "detailed and complete enough that they provide a full and revealing picture of what is going on. . . . The key function of rich data is to provide a test of one's developing theories, rather than simply a source of

supporting instances" (Maxwell, 1996, p. 95). Becker (1970) argues that the use of rich data "makes it difficult for the observer to restrict his observations so that he sees only what supports his prejudices and expectations" (p. 53). In the present study, theme analysis of all data was performed before examples were contextualized for the purpose of theory generation and modification. Extensive excerpts were used throughout the analysis to show the views of the participants.

6. *Use comparisons of data.* Miles and Huberman (1984) argue that qualitative studies that evaluate individuals at more than one site should use comparisons in the data analysis because the discussion of different settings can contribute to the interpretability of cases and help the researcher ascertain the importance or impact of various settings. In the present study, data comparisons were warranted because participants were interviewed in a variety of settings, and several participated in in-depth or focus group interviews at more than one site.

7. *Integrate research participants' views into the interpretive framework.* A threat to valid interpretation is imposing one's own framework or meaning, rather than understanding the perspectives of the people studied and the meanings they attach to their words and actions (Maxwell, 1996). Maxwell further asserts that

> The most important check on such validity threats is to seriously and systematically attempt to learn how the participants in your study make sense of what's going on, rather than pigeonholing their words and actions in your framework. . . . However, it is clearly impossible to deal with these problems by eliminating the researcher's theories, preconceptions, or values (p. 91).

Maxwell warns that whenever a qualitative researcher imposes theory on a study, it can lead to some degree of

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Shoehorning questions, methods, and data into preconceived categories and preventing the researcher from seeing events and relationships that don't fit the theory. . . . To be genuinely qualitative research, a study must take account of the theories and perspectives of those studied, rather than relying entirely on established views or the researcher's own perspective (p. 36).

Using Maxwell's recommendation, the present study addressed this threat to validity by developing theories and continually testing them and by looking for discrepant data and alternative ways, including the research participants' ways, of making sense of the data. Examples of discrepant or exceptional data, particularly cases that did not appear to fit the general patterns, are provided in Chapter 5. In addition, the investigator considered rival hypotheses and alternative explanations for many of the theoretical conclusions.

8. *Link empirical findings to the conceptual material of the existing literature.* Gilgun argues that the use of concepts from existing theory to frame new qualitative data is a form of cross-validation:

Linking empirical findings to the literature also raises the level of abstraction of findings. The products of this research are conceptualizations based solidly on empirical data. . . . The openness of induction is often combined with the more deductive processes of hypothesis testing and cross-validation of empirical findings with existing literature (p. 117).

The following chapter will present a synthesis of findings from focus groups, interviews, and participant observations in light of the various domains of the theoretical framework, as well as conceptual interpretations of these findings and excerpts of data-texts that illuminate the emerging themes.

CHAPTER 4
RESULTS

This chapter offers an organized synthesis of research findings, with emerging themes and categories presented and interpreted within the eight major domains of the theoretical framework described in Chapter 2.

The following section highlights the investigator's observations during the data collection process. The subsequent discussions integrate data excerpts, interpretations, and observations of participants and their narratives in relation to factors that facilitate or inhibit AIDS dialogue and AIDS preventive behaviors.

In each section, findings will be presented using the eight theoretical domains as an organizing framework, as well as the emergent theory within each domain. A model based on themes that emerged from the data is summarized for convenience in Figure 15 on the following page. Exceptions to this framework will be described in detail later in this chapter.

Each section of the chapter will begin with the organizing model, representing the overarching framework of the study, with the appropriate domain highlighted. Subsequent sections of the analysis will follow systematically through the entire framework.

FIGURE 15: Revised Conceptual Framework Based on Data Analysis

INDIVIDUAL PROCESSES

Predisposing Factors
Personality
Demographics: Age,
  Gender, Education, SES,
  Religiosity
AIDS risk factors
Teen sex, pregnancy
Alcohol and drug use
Truancy
Sexual abuse
Sex-ratio imbalance
Motherhood norm
AIDS knowledge
Condom use

Cognitive Processes
Learning
About prevention
Sexual scripting
Social learning
Sexual scripting

Motives
Health beliefs
Susceptibility
Threat, severity
Consequences

Attitudes
Sexual revenge

Benefits

Enabling Factors
Self-Efficacy
Modeling
Heritage reminding
Achievement orientation
"Making it real"
Dialogue (AIDS, sex)
Telling "our stories"
Comm. skills, tools
Empowerment of teens
  & women
Female opinion leadership
Religious values reinf.
Forging inroads
Compassion
Social support for PWLAs

MESSAGE DESIGN & DELIVERY
Source credibility
Cultural sensitivity
Preferred channels
Message content:
  Abstinence
  Condom advice
  New ideas
Fotonovela eval:
  Comprehension
  Messages, info
  Visual appeal
  Age level
  Realism
  Raps, steppin'
  Humor
  Fear appeals
  Dialogue barriers
  Dissemination

Normative Processes
Diffusion process
Popular norms
Prescriptive norms
Pastoral norms
Peer pressure
Church influence
Parental influence
"Watching for the signs"

Potential Barriers
Lack of Efficacy
Familiarity
Fatalism
Lack of parent-child comm.
Denial
Secrecy
Desensitization by drama
Lack of AIDS knowledge
Homophobia
Religious taboos
Church taboos
Church politics
Expectation for divine healing
Church as false protection
Black genocide theory
Stigma
Euphemism, labeling

OUTCOMES
Involvement
Identification
Modeling
Persuasion
Willingness to talk
Dialogue initiation
Behavioral intentions

Environmental Factors
Family Norms
Local AIDS Situation
Community AIDS
  Prevention Resources

CULTURAL CONTEXT

Innovativeness → *Innovation* → *Knowledge* *Awareness* *Persuasion* *Convergence* *Opinion leadership* → *Decision* → *Adoption* *Implementation* *Confirmation* *Consequences*

DIFFUSION OF INNOVATIONS PROCESS

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Predisposing Factors

Figure 16 below depicts the overarching framework for this study, highlighting the predisposing factors, as identified by research participants, that could predict whether individuals will engage in AIDS dialogue or comply with AIDS prevention advice.

INDIVIDUAL PROCESSES

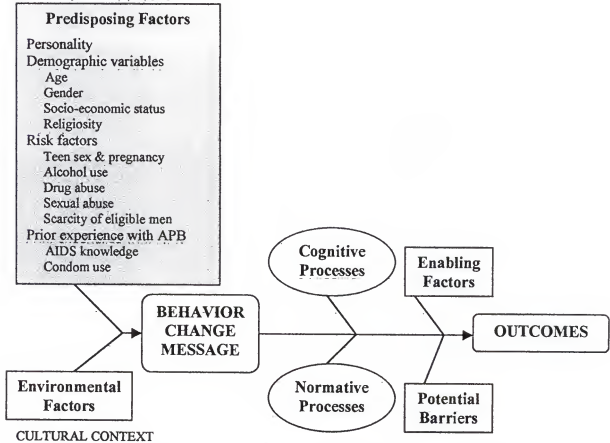FIGURE 16: Predisposing Factors, Identified by Research Participants, That Influence AIDS Preventive Outcomes

Personality

Sensation seeking, a personality characteristic, may be a key motive for sexual involvement among some African American teens. A boy in the first focus group session remarked, "I'm gonna tell you – why they have sex is because they want to experience something that they never had."

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Depressive tendencies also may lead some teens into drug use or sexual involvement. One girl suggested that teens use illegal drugs "maybe because they're depressed or stressed or something." But another girl disagreed with her, arguing that "very few teens are doing it because of depression."

Age

Older age may be a predictor of perceived self-efficacy among African American females. In comparing adults with teens, one woman commented that "we believe we have control over what we're doing, but they're just getting started out there." Higher age also could be a predictor of perceived susceptibility to AIDS. One woman believed she was not susceptible because of her age, remarking that "with me, I think it would be different because I'm older, and I'm more mature, now that I don't just jump for anything." However, another woman encouraged the first woman to place herself in a young person's shoes: "But, when you put yourself back a few years, you were at this point."

Even if the most religious African Americans in Gainesville are middle aged and older, the primary target of church-based AIDS education efforts should be adolescents, one male minister argued.

Among young children, it is unclear whether sexual activity is an expression of curiosity or the initiation of sexual involvement. According to several focus group participants, many African American children begin having sex outside their homes, even without access to secluded places. For example, one boy in the pilot group said he witnessed youth younger than 12 having sex in the school bathroom.

Sexual experimentation among young children often may be seen as evidence of molestation at home. As a kindergarten teacher, one woman once witnessed an incident in which a boy on the playground leaned up against a pole while a little girl lifted herself up, wrapped her legs around his, and mounted him. After the teacher separated and questioned the children, the girl remarked, "I just had the urge to do it." The teacher commented that "to me, that's a sign of somebody fondling her at home." A similar incident happened in a kindergarten ladies' room:

> I walked up on kids in the bathroom doin' the nasty – touching each other, fingering each other. And they say, 'My momma say I could have a boyfriend.' 'Do you know what a boyfriend mean?' That's the first question that come out of my mouth.

Given that the booklet was designed for middle-school aged teens, one woman argued that this target was appropriate for the *fotonovela* because many in this age group are "out there having babies early." She added:

> Those are the main ones that will probably get it and don't even know they got it until it's probably too late. They think they're older before their time, and this is what happens. We're mainly focusing on the young ones to get their brains right so that they won't have to suffer through this. At least they can be more conscious about what's out there in the world, and yes, you can get it if you don't do right.

Even though a few women thought the tone of the *fotonovela* was "mild," one girl argued that the booklet should contain a warning for parents: "I think if they have like young children, they should probably put like a little parent advisement thing on it." Another remarked that "it shouldn't get any worse than this for kids."

An evaluator argued that the *fotonovela* would not be harmful for children who are not knowledgeable about sexuality or AIDS issues. She commented, "I'm sure the

younger kids would have an idea of what it is, but it wouldn't hurt them to get a little more information about sex."

One woman recommended a separate *fotonovela* targeting African American children under 12. She said many young children

> Can tell you something that turn your head around 20 times. We're always talking about teenagers, but we got to get to this bottom section to get their minds focused on what's really happening in this world, because they're starting at a young age.

Despite developmental differences between boys and girls and between older and younger teens, the *fotonovela* has a common appeal among many African American youths, one woman argued. She commented that the booklet "is very good for a lot of young people in different situations that they can relate to."

In discussing the selection of facts for use in the *fotonovela*, several women debated the level of intensity that is appropriate for young teens. One woman argued that to "show the effects of AIDS diseases and processes . . . may be a little bit too strong" for young teens. Other women disagreed:

> Woman 1: When you're talking about things like that with elementary kids, how intense should you get with this information when you go past this age?

> Woman 2: Very intense. Let me tell you something. Most high school kids can teach an AIDS 104 class.

> Woman 3: Most kids have experienced something already.

Gender

Teen girls may have a greater concern about the consequences of sex and AIDS than boys do at that age, possibly because they may take the issue more seriously. When asked to guess about how the boys reacted to the "On the Pillow" video, most girls said

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the boys usually act immature, disruptive, or indifferent. One girl, however, still believed the boys were listening to the advice in the video:

> I think the boys are acting very immature, but then on the other hand, I think that the guys are listening. They might act immature, but they're gonna listen and they're gonna at least come around when they are mature.

Another girl commented that "some boys don't really care about their life. Some boys be like all acting crazy." Then a girl added: "They're probably sort of acting like, you know, stuff like, 'That's cool' and junk, but they're just hanging around and they not going to do like you want them to." One girl believed that the boys liked the video because they already engage in risky sexual behavior and do not feel vulnerable to the possible consequences: "I think that them boys thinking 'all right' 'cause they like do that kind of stuff like that. It's kind of like retarded, but they shouldn't do that."

Socio-economic status

Socio-economic status among African American teens may be linked to their selection of AIDS information channels. Most boys in the pilot group came from a higher socio-economic background than did the boys in the summer youth program group. Many parents of pilot study participants were highly educated professionals such as doctors, nurses, and lawyers. Most boys in the pilot group cited media as their primary source of AIDS information, particularly television, radio, movies, and albums.

All the boys in the summer youth program group lived in subsidized housing. Most said they received most AIDS information from a sex education class at school or from their parents, but not from the media. They may have relied on these interpersonal channels more heavily than mass media channels because of insufficient access to media

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or because they live in a sub-culture within subsidized housing areas that strongly reinforces word-of-mouth communication.

Similarly, all the girls in the summer youth program group said they received the most information about AIDS from school. Various girls said they remembered seeing a video and hearing a man with AIDS speak to seventh grade classes. One girl said she has never seen a television public service announcement about AIDS.

One woman who lived in a subsidized housing area said she got much of her AIDS information through interactions with public health outreach workers, even when she had a streetwise lifestyle:

> When I was out in the streets, partying and everything, I was getting my information through the health department workers, you know.

Religiosity

Several girls recommended that African American teens go to church activities at least once a week. The recommended frequency of attendance ranged from "every time they wake up" to "every Sunday" to "every time they have a chance." One girl disagreed, arguing that teens are not as religious as adults:

> If you saved, then you should go every Sunday. But I'm saying like teenagers, they should go like two times out of one month.

More than just a place for common worship and religious expression, the church also is seen as a kind of extended family. One woman remarked that "your church is supposed to be your home, your family."

Several girls commented that church is a "good" and "marvelous" "place to feel good about yourself." However, a couple of girls pointed out that some attend church to be entertained. One observed that "a lot of people just go to church and laugh at them

people shouting." Many youths may be afraid to express their religiosity in church unless they are emotionally moved by a worship experience. One woman said she secretly watched her 21-year-old son as he sat in church on Sunday to see how he was responding to the service. She observed that

> If you watch a face in the church, you can tell if they in the mood for the church, or are they curious what's going on. I kept focusing on his face to see what he was feeling. I could see he enjoyed it. He was sitting there, kind of controlling himself, 'cause you know how men when they get that age, they macho. After a while, the Holy Ghost kept flowing in the church, he jumped and whooped with the pastor.

Several girls indicated that African American teens are more religious than white teens, for various reasons. When one girl speculated that "black teens have more problems than white teens," another said this could be the case because "their problems are probably more serious." One girl argued that African American teens are more religious because "that's how they were brought up." Another agreed, adding that "white teens aren't brought up as serious Christians as most black teens are."

The style of worship may be quite different in black churches, compared with white churches. One key informant from the Task Force remarked that her son asked a white man at First Assembly of God "if they believed in shouting, and he said, 'Yeah, we get real loud.' That's where I'd say there's a cultural difference."

She also commented that many African Americans do not attend church because the churches aren't trying to communicate with the public about any issues, religious or otherwise. She remarked:

> A lot of churches aren't talking about the gospel or about AIDS. A lot of people are growing up not knowing anything. One lady said she thought Jesus was a type of car, because all she'd ever seen was "Jesus" on people's bumper stickers and license plates.

Because of rising apostasy among many blacks, many only attend church on

Easter, Christmas, or Mother's Day, the key informant argued. A related trend among

many African Americans, particularly among youth, has been total apathy towards

church or religion. The woman observed that

> You have a community that used to be very churchgoing and now there's a lot of
> apostasy. Nobody's making their kids go to church. Some of them say they
> stopped going to church when Grandmama stopped making them come.

Reading the Word

Reading the Bible daily generally was considered to be essential part of being a

true Christian and considered a guide to appropriate and healthy behavior. One woman

commented:

> Being a Christian, you're reading the word of God. He's telling you all these
> things that He would not stand for. If you want to live and be like Him, you have
> to follow His rules, His commandments. There's no substitutes about that. If you
> want to be like Him, you go up there where He's at, you gonna have to do what
> He say. You cannot go like, 'Well, I'm gonna do this anyway. That won't
> matter. I'll repent later.' That's too late. You can't do it both ways.

Another woman commented that reading the Bible helps Christians identify their

own and others' sins and put these "mistakes" into perspective:

> A lot of things we see going on in life actually has not surprised us because it's in
> the Word. And I think that helps a lot of times. I see several people still make a
> lot of mistakes, even though they know they've been taught. Their parents have
> done everything they're supposed to do sometimes. They still make those
> mistakes, or they still fall into it because they thought it was that one right person.
> The more being able to read the Word or hear the Word, it helps you to actually
> identify yourself within it.

The "inner spirit"

A tenet of African American religiosity appears to be the belief that when a

Christian pursues a daily walk with God, the Holy Spirit "speaks" and guides the

person's behavior from one moment to the next. It is unclear whether a Christian's

reliance on this divine inner spirit could be a barrier to the prevention of risky behaviors, as it could lend a false or irrational sense of protection, or that it could actually enable a person to effectively banish such behavior from his or her life. One woman described this inner spiritual voice this way:

> Being a Christian, when you getting ready to do something, your inner spirit will let you know. You will get that feeling or you will hear something in your head, saying, 'No, don't you do that. It's not the way to do that. Don't go that way. Don't do that.' You will get that inner spirit, that word spoken to you, but it's up to you to heed what it's saying to you. 'Cause if you like, 'Oh, naw. I'm gonna ahead on and do it anyway,' then when you go and do it then, 'Uh-oh. I should have listened, 'cause something told me.' Your inner spirit told you not to do that.

While an irrational decision is driven by emotions or physical desires, and a rational decision involves the weighing of costs and benefits, a spiritual decision appears to be based upon guidance from God's voice, Bible interpretation, and other Christians. One woman explained that living as a mature Christian involves surrendering control of oneself to God, while recognizing the consequences of disobedience to His will:

> Being a Christian, you get a lot more help because God makes it available for you. There are things that you would have allowed yourself to do before you became a Christian. You will not allow yourself, because now, you're not a babe. Sometimes a babe can make a real good decision, but if you've been in the Word and you really, really want to live for Christ, you gonna know the do's and the don'ts. If you keep doing these things over and over, and He says, 'Don't do it,' there's a price you have to pay.

This woman not only feared God, she also feared that her sin might hurt Jesus and herself:

> If you fear God, you will not do a lot of things. You know that when you do something like this, you gonna be hurting Jesus. I mean, it's there in the Word. You're gonna be hurting not only Him, but you're gonna be hurting yourself.

In addition to seeking God's voice through prayer, she also seeks accountability for her actions from other Christians:

If you are a Christian, you're constantly there because the pastor, different ones around you, 'You shouldn't do this.' It's not just the Holy Spirit always saying these things.

Before she became a Christian, one woman said she did engage in risky sexual

behavior, but she would not do these things now because her inner spirit protects her

when she is confronted with temptation:

I wouldn't say that it would have been different when you were in the world, but now, first of all, you've got more in you because you've got the Holy Spirit on the inside now. And He leads and guides you, and He will say no, say no.

Another woman attributed her growing interest in AIDS issues to God's voice,

manifested through her daily prayer life:

I myself didn't know a lot about AIDS for a long time. But as I prayed, God told me I was going to be greatly involved with AIDS. And at that point, I didn't know hardly anything about it. As I become more aware of it, the more I want to be involved with this to try to help.

However, not everyone agrees about how this inner advisor should be consulted.

For example, when one woman claimed her inner spirit could tell her if her husband is

cheating, another woman scoffed at the statement:

Woman 1: "Her inner spirit should give her some kind of uneasiness."

Woman 2: "Please!"

One woman challenged the efficacy of salvation and spirituality in preventing

"slip ups" when she brought up a recent news story about a prominent minister, the head

of the national Baptist association, who had been exposed in an adultery scandal. Her

question about this incident sparked dialogue about sexual mistakes among Christian

leaders:

Woman 1: Tell me what happened here. They found out that he has a woman on the side. That's what I'm sayin' 'bout how you never know.

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Woman 2: He done forgot about God, about the Holy Spirit.

Woman 3: A lot of people say, 'I'm saved, and I won't make that mistake. I'll be this way.' But I think people are falling every day for the same reason. It doesn't mean they're bad people. They make mistakes. All of us can make mistakes. It doesn't matter how close we are to God. Even though some of them seem to be small mistakes, still yet even like that preacher –

Woman 4: What about his conscience?

Woman 1: He had probably been doing this for awhile. If this is true, he could have been doing it for years, and getting away with it. He may have had this problem. Do you know how many people that have problems and they hide it for years? And then when they put them on the TV, they want to say, 'Well, this is a preacher. How did this happen?' This is happening every day.

Woman 4: Amen.

Woman 2: It makes you wonder if he really knows God. 'Cause he's a preacher. That's it. That's what he's committed to.

Woman 3: He's just a man, but he's in authority and that's why it's pointed out. Because if it was me, any of us in here, nobody probably would even care. It wouldn't make the headlines. But yet we're doing the same thing. And not to say that he probably don't have the Holy Spirit. It's just that he's weak in that area. Maybe he has not been praying and confessing like he should, or maybe he's having home problems."

The last woman appeared to believe that the fallen minister was saved and "had the Holy Spirit," the two prerequisites of spirituality that many women believed to be protective factors. However, she argued that he was just weak and was not routinely engaging in religious practices – prayer and confession – that should promote a level of spirituality sufficient to protect him.

The life "out there"

Identifying oneself as a Christian sometimes promotes the sense that Christians live within a protected subculture that transcends the sinful world "out there." Several

women in the focus groups also referred to their pre-Christian lives as "out there," the time prior to a particular moment when they experienced a spiritual conversion.

One woman reflected on her past life in the world "out there," and concluded that she had engaged in risky behavior during a partying phase of her life, but later decided to devote her life to Christ and become sexually abstinent. She began to share these feelings after another woman asked her about past "mistakes":

> Woman 1: OK, in one night, you mean to tell me that this man come up to you, and when you was out there in the world, you would have just went and slept with him right then?

> Woman 2: Yeah. Because the thing is when you're out there, you're not thinking about AIDS. You're not even thinking it's gonna happen to you. That happens to other people. That happens to the people down the road, not you.

Although one woman argued that being a Christian often "makes you think" about your own thoughts and actions more introspectively, there may be no significant difference in the decision-making processes of a Christian compared with a non-Christian:

> I say there's no big difference whether you're a Christian or not. Sometimes somebody who's not a Christian can make a very wise decision. The person that's a Christian can do something that's not as wise.

Another woman argued that merely having a moral or rational conscience is not sufficient to prevent a person from engaging in risky sexual behavior. After people experience a spiritual conversion, they are no longer "out there," and they begin to care more about others as well:

> See, when you're in the world, you don't have that conscience. It's surprising, but it doesn't like let you know that you shouldn't do this. If you're really out there, you're out there. You don't really care who it hurts. So when you come into church – no, not into church but when God comes into you – then you start caring about other people. I think it's different for me 'cause I know when I was

out there, I didn't care. If I liked him, I just liked him. I didn't know what the different situations would be. I didn't want to get into all of that. But now, if that would happen to me, first of all, I'd be hurting somebody. Somebody else is going to get hurt in that situation.

The difficulties that people have "out there" sometimes can draw them into the church in the first place. As one woman involved in community outreach remarked:

I see a lot of times people come into the church because of things that have happened to them out there. I don't think you just walk in and say, I think I'll just go to church faithfully every Sunday. Something has happened to have driven you there.

However, given that Christians are supposed to serve as models of morality to others, many Christians may assume that their own failures will discourage the people who are living "out there in the world" from seeking salvation. One woman observed:

Sometimes church women and church men should be an example to people in the world. We're doing things that are not right, so therefore in the world they see us out there, and they do the same thing. In our church, we've got men and women that are having sex before they're married, having kids while they're there and not married, and doing all these things. So, why wouldn't the world come in and say, 'Well, they're no different from us.'

Evangelism

Even when a women's focus group moderator asked numerous questions about the *fotonovela* and general AIDS communication strategies, many women responded instead by discussing evangelism strategies. It appeared that the women were framing the concept of AIDS-related dialogue using their own experiences of community evangelism and were viewing AIDS dialogue and evangelism as similar tasks in terms of importance, seriousness, urgency, and strategies.

The concept of "planting the seed" is a central tenet of Christian evangelism. Reflecting on her own evangelism experiences, one woman remarked:

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When you're trying to talk to them, a lot of times they may not come right then. But you plant the seed, and you teach them what you can teach them. And it comes a time when they will take it in.

Given the urgency of preventing a spiritual downfall, one woman argued that the conversation must occur "hopefully before it's too late." Another woman believes this prevention is entirely up to God. She explained:

You plant the seed, and let God do the watering. You got to realize they got to want that first, a new change or whatever they want. They've got to accept Christ on they own. You can't go out and browbeat them. God don't want it that way.

A potential barrier to sharing a salvation message with non-Christians is their skepticism about praying to an invisible supreme being. One woman recalled a typical remark she hears whenever she tries to persuade others to receive salvation:

'Hey, that's somebody they praising, and that man ain't real. I don't see him.' If they don't see a person, they ain't gonna believe in that person. Some people just like that.

Given that HIV is an invisible virus, usually transmitted without notice and infecting a person for many years without symptoms, perhaps a lack of "faith in the invisible" could be framed as a barrier to perceived susceptibility to AIDS as well as a barrier to religious salvation among African Americans.

Apparently, conversations about AIDS and sexuality can be contexualized within evangelistic outreach. In sharing the *fotonovela* with teens in her neighborhood, one woman talked about AIDS issues in light of her own religious faith. She said the teens responded positively to this approach. Reacting to this story, another woman commented:

I like to hear that they were very receptive to Jesus first, 'cause a lot of kids are still out there on their own and do not want to hear the word of God.

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One woman compared sharing the *fotonovela* with handing out religious tracts to youth on the streets. She related:

> Me and my cousin saw two little couples standing on the sidewalk. And I called out to them, 'Do you know Jesus loves y'all? I just want you to read this.' They say, 'Yes, ma'am.'

Evangelism also may be a tool for helping non-Christians change their unhealthy behaviors. One woman who is involved in evangelism said that being a Christian helps her assist people who are living in sin:

> I think being a Christian definitely helps you deal with things that are not in the church, that y'all never deal with. They're dealing with sin and what the effects of it is, the different things that can actually happen from it.

Another woman agreed with this approach to AIDS education, remarking that "we most certainly want to witness first to their hearts and souls. There are those we meet on a daily basis or those you interact with on the street. They aren't ready to receive salvation."

While many youths may not be persuaded easily to accept spiritual salvation, several women argued, the church can offer them a place to experience the love and acceptance they may not receive at home or from their friends. One woman suggested that the love offered by the church can motivate youth to maintain a moral and healthy lifestyle:

> The love the church has, it makes a difference. A lot of young people, they really want to know that somebody loves them. 'Cause they want to know, 'I can go back to this church where I know these people really love me.' If they say to do things, then they'll just say it. But if that person be in a church, you will always keep it. You get a young person into that church, and someone comes up and says, 'I love you,' and you keep that love going, that's what a lot of young people want. They don't have it at home, and they need it. They're looking for it.

Conversely, many youths have sex because they are searching for love, one woman speculated. Thus, a key to preventing AIDS among teens may be to ask them questions about their spiritual needs and then to help fulfill their need for love through involvement in a church community. The woman remarked:

> Some kids are really reaching. That's why I be talking to different people, trying to find out, 'What you searching for? Are you in love with Jesus? Come on with me to church. I'll arrange a ride for us.' Once they come and see how the people in the environment is, and how the spirit of love flowing through them, they can't help but come back. A lot of them get saved at that moment.

Bringing teens to church potentially can lead to problems, however. One woman argued that the church is not actually providing what youth want and need. She remarked that "most teenagers are looking for love and comfort, and the church is not giving that love and compassion." Furthermore, if youths feel they are expected to participate in church activities or to present themselves as "saved" Christians, this pressure may motivate them to rebel. One woman lamented that her own children may have turned away from God, and she fears that her attempts to involve them in church may have led to this apostasy:

> I found you can be so deeply saved and a Christian, and you want to put that on your kids. And all it does a lot of times is run them away. Once we get to be parents, and we get to be in the church, we feel like all of a sudden we get these sanctified kids. My son, I heard him talking with one of his friends, 'My momma thinks because she's saved, I'm supposed to be saved.' Because I would not let him go to something he wanted to go to. I had to stop right then, and go right in there and start talking to him, 'You know, I'm not saying that you're saved, but it's my job to teach you what's right, what you should and should not do.'

The "slip up"

Both women and teens in the focus groups talked about the likelihood that most people will "slip up" at some point and engage in risky sexual behavior even if they know better. They talk about a "slip up" as if it is inevitable and unavoidable, an action beyond

rational control. As one woman commented, "Sometimes, adultery just slips up or fornication slips up, and it happens."

Traditional wisdom may say that learning from one's mistakes is the most effective kind of learning. However, several women pointed out that it takes only one "slip up" to contract AIDS. One woman commented:

> A lot of times people don't learn until after they make the mistake. And then they're in it. So then, they find out, 'OK. I really messed up.' And that's really a fatal way to try it.

Usually the "slip-ups" were discussed in the context of infidelity in marriage. One woman recounted a true story to illustrate her point that "slip-ups" are very common:

> You remember one of the doctors that came and talked to the kids at church one time? He told the story about the man and woman who had the baby, and the baby was tested for AIDS afterwards. They were already married, and they were saying that, 'It wasn't me. It wasn't me.' And come to find out, one did slip. I mean, it's every day.

The marriage contract may promote blind trust among many African American women. One woman noted that most married couples do not use condoms "because they don't feel like they need to use them." In addition to recommending condom use within marriage, another woman argued that wives should educate their husbands about the dangers of extramarital sex, even if it is a difficult topic to discuss:

> I feel like as women, even though our husbands are not here tonight, it can help us even talk to them, to let them know how much if they make that one mistake, it can not only hurt them it can hurt you. Adultery and all is not just a sin, but it's something that can cost you your life.

Teen sex and unwanted pregnancy

A female pastor estimated that 90 percent of African American teens already are having sex, but that many are probably using condoms: "You may find out of 50, maybe five that's not. A lot of them are more aware about condoms, so they are being safer."

When asked what kids really think about having sex, one girl commented that "they think it's cool and fun." However, another cautioned that "in a moment's time it goes away." Then another added that kids do it "to get close and stuff." The reasons that kids have sex, according to several girls, included irrational impulse, desire for love, revenge against a parent, and desire to please an attractive boy:

Girl 1: Some of the reasons, I feel, are made irresponsibly, and some of the decisions are not made in the right mind.

Girl 2: They do it to get love, 'cause some people – they have a TV show on last night – they said they need to have sex 'cause they momma don't have love in they home.

Girl 3: It's just to get back at your momma and stuff.

Girl 1: 'Cause they have this boy, he's fine.

Alcohol use

Several focus group questions for youth addressed alcohol and drug use because these behaviors are linked to risky sexual behavior. In addition, substance use was a relevant and popular topic among many focus group participants. This may have been partly because the "On the Pillow" video they watched portrayed the main character, Terrence, engaging in unprotected sex after becoming intoxicated from drinking beer with his friends at a bar.

All the boys perceived that drinking is common among their peers, either because they themselves have done it, their friends talk about it, or they see physical evidence that others are drinking. When asked how common drinking is among kids in school, one boy admitted, "I know it is, 'cause I used to drink at school, man." Another commented that "a lot of teenagers say they like drinking beer, like having fun." One boy observed the

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litter on the school grounds: "Sometimes we walk, like, to school early in the morning. I see some beer bottles around here."

A boy in the pilot group commented that some of his friends are allowed to drink at home. Another remarked that "some of them drink booze." Two boys in the pilot group related a story about kids at church spiking some Kool-Aid with whiskey. One boy said:

> I know when the bishop was lecturing, they was getting into Jack Daniels, beer, and all that. They put it into little orange cups, and they like, (slurp noise).

Then the other boy finished the tale:

> Yeah, the teacher was like, you know, a cop will make you walk the line. And she was like, come walk the line. And everybody was like, nah, make James and Kevin walk the line. They acted like it was Kool-Aid. They had a bottle of Jack Daniels. It gave them a headache. They was sick for the rest of it.

Although one girl contended that most teens her age smoke cigarettes far more often than they drink, another added that drinking is still "very common" among kids in her school and estimated that "one out of ten students is getting high, and five out of ten are drinking.

One woman asserted that although drinking may reduce inhibitions, it does not explain why many people engage in risky behaviors. She remarked that "some of them do not have to drink anything -- kids as well as grownups even as well as women."

Another woman admitted that her past life "out there" involved occasional one-night stands, but she argued that she had made every effort to maintain rational control in situations where drinking alcohol might lower her inhibitions:

> I was out on my own when I was 15, out there in the world partying, drinking. But when I drank, I would drink maybe one can, 'cause I wanted to be focused. I wanted to know exactly where I'm going, what I'm going to be doing, and

everything. 'Cause you wouldn't take advantage of me. I had that much common sense. I was partying, but I had sense enough to know when to stop.

Drug abuse

A female pastor said African Americans are more at risk of HIV infection because

"a lot of our people are more on drugs." She said drug use and trading sex for drugs are

typical aspects of a streetwise lifestyle:

> It's like very easy for them to get involved with it when they are out there on the street. Once they get out there on the street, they usually have to do a lot of different things just to get their drugs. The ones that are on crack, a lot of them I think have AIDS because they're out there sleeping with anybody just to get some drugs.

Reaching out to drug abusers in the community is a challenge for AIDS educators,

a key informant said.

> You don't want drug dealers to think you're a non-paying customer. They're running a business here, and you'd be holding up their business (by giving them AIDS literature).

One woman said she sees African American teens constantly hanging out in

groups within low-income housing neighborhoods, and often they use drugs in the

daytime in public view:

> I see these kids every day drinking, smoking, doing drugs. And I say, what grade you in? They say, 'the eighth.' The older guys give it to them. And I say, 'Do you know what you're doin' to yourself?' And they're like, 'Yeah. I'm having a good time.' A lot of their parents are always in the house or they're always gone to work. All day long, I see the kids, but I don't see parents.

One boy believed the existence of a drug education program at his school showed

that drug use is common among his peers. When asked, "How common is drug use in

your school?" he responded, "They talk about it in a program in our school, like they talk

about it all the time. They say stay away from drugs, stay out of trouble."

A girl said drug use is much more common in high school than in middle school. A few girls indicated that some African American teens use crack and that many want access to marijuana. One girl said no one she knows uses injecting drugs but "they crazy if they do." Another feared being implicated by discussing whether other teens in her school use drugs: "I've heard about it, but it's not like I know." A couple of girls observed that some drug-using teens lead a double life:

Girl 1: I know they do it, but they don't brag about it.

Girl 2: They still have a good reputation with the teachers.

The social image of crack-using teens is not always glamorous among African American boys. As one boy commented, "They gonna be a crack head." Even if crack use is common among African American adolescents, it may not be acceptable for them to use it around adults. One boy observed that "they might don't seem like they're doing it, but you know, they may hide it in their room." Another boy said he'd tattle if he caught a friend using crack: "If I see somebody doing it right now, I'd tell their parents or their mom."

Among boys in the pilot group, there were mixed opinions about whether many African Americans in Gainesville use intravenous drugs. One boy in the pilot group said he knew an African American teen who experiments with drugs. Two boys in the pilot group commented that marijuana use is most common among white teens. When one remarked, "I know a lot of white kids who smoke pot," another boy added that "the majority is white."

A female pastor who coordinates church outreach efforts within various housing projects observed that many elementary and high school youths in low-income areas are drug users:

> The first thing they get into is drugs, especially crack. They're more into marijuana than any other drug because they start off there. So many of them are selling drugs already. That's why we see it to be so important to get out in those neighborhoods to let them know they actually have a choice, but not beat them down with religion.

One boy said people use illegal drugs because "it make them feel good." The easy accessibility of drugs may increase drug usage among many African American teens. Two girls speculated that teens use drugs "'cause it's easy for them to get to it," or because "they just want it, and it's just there."

Several boys in the focus group, as well as in the pilot group, openly described various kinds of drug use practices and paraphernalia. Savviness about these matters may be a considered a mark of masculinity among pre-teen African American boys. For example, when asked what most African American teens think about using crack cocaine, one boy simply explained that "they put it in ice cubes. Then they cut them up." Another boy recalled seeing a hangout for intravenous drug users in another city:

> I lived outside a city, near a harbor. There was a big warehouse. They go there, and you know they gonna do injection, like crack.

Then it occurred to another participant that maybe this boy was really talking about himself and asked, "You try cocaine, boy?" Another boy in the pilot group recalled an intravenous drug user he once knew:

> This one man, he used to live in this basement in New York. That man shot up so much he was in no more pain. Every Friday night, he'd bring like five new people down there and shoot up. You'd have to pay $20 to get in.

Not all teens shunned the use of illegal drugs. For example, one girl argued that illegal drugs should be legalized because "it's not much of a hassle to have it. It should be legal because people are making bad chemicals. It should be legal to make it safer." When asked, "Speaking for yourself, what difference does it really make whether kids use drugs or not?" the same girl departed from the expected, socially desirable response by defending a person's right to use drugs in moderation:

> It depends on what they're using, and if they're overusing it. I know that people I know, they're not overusing so their life is going all right. But if you overusing and it's causing a problem like with your family and stuff, I really don't think you should do it.

Although most teens may consider drug use to be taboo in many social contexts, most boys considered the potential stigma or legal consequences to be more threatening than any perceived health risks. As one boy commented, "If they mess around and go to jail, they might not get out until, like, a year." Among the boys, the perceived health risks from drug use are the risks of overdosing or being poisoned, not the risk of HIV infection associated with impaired judgment. One boy wondered if smoking marijuana could be just as dangerous as injecting heroin:

> Most people say that marijuana is the most dangerous drug. But what about heroin? Which drug is most dangerous? One day, you're messing around, and you die because you're smoking or doin' heroin. The carbon monoxide goes in when you breathing.

These comments showed that many teens are curious and want more information about substance use issues. For example, one girl remarked, "We need to know about it before we face that problem." A female pastor asserted that having a former drug addict speak to youth about the consequences of drug use is far more effective than having a parent or minister lecture them:

A Christian or their parents may talk to them, and those may be the only adults that try to tell them. They think, 'These are just old fobies. They don't know what it is to have fun, so they'll try to stop us.' Unless they see some of the bad things that happen from it from somebody who's experienced it.

Despite a desire to learn more, most teens seemed to be indoctrinated with the anti-drug messages that have been promoted in the mass media and in schools. For example, at the end of each topic discussion when the female moderator asked the girls if they wanted to add anything else, several girls usually volunteered their advice. Their messages about drug use included: "Don't overuse drugs," "If you use them, be careful what you do," and "If you go crazy, you might walk over a bridge or something."

A male minister commented that most African American churches in Gainesville are able to freely discuss drug or alcohol abuse, but a few churches do not address these issues. He commented that "talking about the use of illicit drugs used to be absent in churches, but now the dangers are talked about." A key informant observed that many clergy preach an anti-drug abuse message, but they do not acknowledge the possibility of drug use within their congregations.

When asked what they would do at a party where everyone is drinking or using drugs, several boys said they would probably leave so they wouldn't get into trouble. However, the motives for leaving varied. For example, one boy said he would leave to avoid being pressured into using drugs: "They'd try to make me try some of that dope. If you stay like that, they'll try to convince you." Another boy feared that he would be punished by his parents. His description of the consequences may have been too detailed to be merely hypothetical:

I'd believe I'd go right back home. If they're smoking marijuana, you come home with your clothes smelling like that, and your mom or your parents would say you're lying.

One boy said he would leave the party to avoid getting involved in a fight, and recalled witnessing this situation firsthand: "They were using drugs outside my apartment, and they started fighting on the ground."

When asked the same hypothetical question, one girl admitted that she would "probably drink a little bit if they were smoking hemp or marijuana and drinking." Another said she would just leave the party, but one girl said she would "just sit there" and not drink. In order to fit in, one girl said she would "take a beer can and go back and get some water."

Truancy

A key informant said that many African American youths learn about AIDS on the streets because they do not attend school frequently enough to learn it there:

> They're not learning about AIDS like they should, except if they learn about it in school. But school attendance is poor. Most of them learn about it on the streets. Probably a lot of incorrect information.

Another key informant observed that many African American youths who are at a higher risk of HIV infection are high school dropouts who enroll in the Job Corps. Many of these teens cannot complete traditional schooling, so Job Corps centers provide job training and academic classes. While the youth are learning these new skills, they live in a dormitory at the Job Corps site. The key informant commented that this dormitory environment may create conditions for the rapid spread of HIV:

> They're all tested before they come here. But I'm as realistic as anybody. I know that when you put these kids together in dorms and they're all right there together and their little gonads are screaming, and you know -- that's three weeks, so someone who's HIV positive can infect a whole lot of people, depending on how they engage in sex.

However, she said the classrooms at the centers could serve as an ideal environment for AIDS education efforts:

> With the youngsters in Job Corps and the juvenile detention center, you have a captive audience and they have to listen to us.

Sexual abuse

Discussion in the second women's focus group frequently turned to sexual abuse issues, and it appeared that many women were personally concerned about it. Several women in the focus groups contended that many African American teens are at risk of HIV infection because they are sexually abused by relatives. The teens' risk factors include infection from the abuser, as well as their own risky behaviors rooted in the emotional trauma resulting from the abuse.

One woman said she tried to help a young lady whose father molested her at home. This girl "was very popular, and it made her from being smart to saying stuff that was nasty, and she got in trouble. Somebody had to talk to her." Another woman related the story of a young girl she knows who suffered sexual and physical abuse from family members for years:

> When she was a little bitty girl, her momma's brothers would come to her in the night and mess with her. One day, she got tired of it, and she went to her mom and she say, 'Your brothers coming in making me have sex with them.' She said her mom beat her up and allowed them to do that, and she tell her, 'You nothing but a liar. My brothers would not do that, but you just making things up.' She was hurt, all the way deep. She came to me and was telling me about it.

Another woman related that incest occurred in her own home when she was young, even though she came from a socially prominent family.

> My grandparents were evangelists and had a high position in the church. During that time she worked on the premises, so she allowed my mother to live with my aunt, who had children. So everybody was family in the church. Children lived with other children, cousins lived with cousins, and one cousin over here. Sometimes these things happen, and incest does happen.

Besides cases of incest, many African American girls are molested by their mother's boyfriends, according to several women. One woman explained that this often happens because "women tend to be so in love with the man so much, they don't listen at the kids. They throw out signs." Parents also neglect their own children in sexual abuse cases when they do not know how to handle the situation. One woman observed:

> The parents cover it up because they don't know how to deal with it. I've noticed when it comes to things that are bad, people hide it. They don't say, 'Look, I made this mistake.' Most people don't know what to do with it. Get some help.

Another woman told a story about a young girl with AIDS, another sexual abuse victim, who showed up at the woman's door:

> She really walked all night. She was so tired. I was talking to her, and she said her mom put her out. She was so young, like 10 years old, started tricking with men to support her momma's habit. You can see that hurt go deep. She used to come to me and say, 'I'm so glad you're home.' And I said, 'Come here, baby. Let's go take you a bath. Go change your clothes, and get in my bed and sleep. Let me fix you something to eat.' You see, I know for myself, I'd want more people to treat my children the same. Any children. I don't care whose children they are.

One woman said that a member of her family was a gay man who died of AIDS. Before he died, he told her that he became homosexual after his uncle molested him. She commented:

> You know, his uncle was a prominent person in the community, head of the basketball team. He was asking me to keep it a secret, and I was like, 'I can't believe this.' Then, when I told a couple of people, they were like, 'Oh, my God. You're crazy!' Everybody in the community knew he was with the boys, you know, coaching basketball, and all the boys went to get on the team. You know, he was molested by an uncle, and he got a homosexual bent. It's a cover up.

Some child molesters hide within the church, another woman argued. She told a story about a church deacon allegedly abused a teen-ager sexually, but opinion leaders in the church "swept the accusations under the rug." The woman commented:

I'm not going to be so easily thinking, 'Well, they're Christians, and they won't do it.' Because a lot of people hide in the church, and they do all these sneaky things. I've seen a guy that molested children. And because he was a deacon, everybody stands up to take their side, and nobody takes the victim's side. When the signs are there, when you go and find out things, don't be so easy to excuse the person and overlook them and pick them over your child or over a friend. If you take out some time to listen and talk to that child, it will come forth. But the reason why a lot of them don't want to bring it forth is because they're protecting someone or they know as parents, 'Don't you tell anybody that.'

Scarcity of eligible men

One key informant encourages her friends to remain sexually pure, even when there's a lot of competition for men. "I tell them, you ain't a Toyota – a man don't need to test drive you first," she said.

The search for "a good man" also was an important issue among many women. One woman remarked that AIDS education is important for African American women because "it's hard to get a real man, just looking at him. He looks good, but underneath that – ." After watching the video "On the Pillow," another woman commented, "If you think about it, when you really look at men today, they are no different from him." Several women appeared to distrust men, in general:

> Woman 1: You don't know what he's doin' out there when he's telling you he's goin' out to get a gallon of milk or some gas or some money.

> Woman 2: That husband's going out to get a gallon of milk, and it's taking him four hours. I want him to take me where that cow was.

> Woman 3: It don't take no four hours going from home to get a gallon of milk. He might want to stay out there a little longer, but it don't take that long to have no sex.

> Woman 1: That's what I know.

> Woman 2: Five minutes at the most.

> Woman 3: Wham, bam, thank you, ma'am.

AIDS Knowledge

The level of knowledge among the teens was generally high, and it was higher among teens than women. When asked how AIDS is transmitted, various boys in the pilot group volunteered that HIV damages the immune system, that it is transmitted through needle use, that the virus was sometimes detected in blood transfusions before 1985, and that many infected people do not show symptoms for 10 to 12 years.

The boys in the summer youth program knew that perinatal transmission of HIV does not occur in every pregnancy. Although the boys agreed that having unprotected sex can lead to HIV infection, several cited blood transmission such as a tainted blood transfusion or contact with broken skin as a higher risk factor than sex. The concept that HIV damages the immune system was also commonly understood among these boys. For example, one commented:

> Like if you got AIDS, and you tryin' to do a lot of stuff you're not supposed to, you can die then. Like drinking alcohol.

Most women were knowledgeable about HIV transmission routes, including needle sharing, sex, blood transfusion. One woman repeatedly brought up the particular transmission scenario of a person becoming infected through contact with someone who has cuts on his or her hand:

> You don't really know if they got it or not. You have to cover your hands if you've got cuts anywhere on you. You have to prepare yourself for that. They might think that you being funny, 'Nah. I ain't got nothin'.' But they don't know that. Best to cover yourself than to be sorry in later years."

Most women were aware that HIV is typically not transmitted through casual contact or kissing, but a news story that ran the previous week raised some doubts

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because the CDC had announced that someone with poor oral hygiene became HIV infected through deep kissing. For example:

> Woman 1: They say you can get it through French kissing, but it'd have to be like a quart of saliva.
>
> Woman 2: That's a lot of saliva.
>
> Woman 3: They keep saying on the TV we don't know exactly how, all the things, you know – they did rule out some of the things, hugging and kissing and toilet seats. They ruled that out.

Condom Use

Most boys made a strong connection between condoms and HIV prevention. One boy warned that if you have sex without a condom, "you know what you're gonna get. You get HIV." One pilot group participant said he remembered a third-grade teacher talking about condoms. Other boys in that group mentioned that middle school teachers sometimes discuss condoms along with other birth control methods, including abstinence.

A female minister commented that among African American teens, the older boys often pass condoms down to the younger boys, along with the advice, "Man, if you gonna do that, you better use this."

After watching the "On the Pillow" video, one boy in the pilot group said he definitely would insist on using a condom, even if the woman tried to prevent him from putting it on:

> If you have a condom, and the girl tell you no and slap it off, you put it on. If she don't want you to put it on, she must not want you to be on. That's all I'm saying.

Another boy in the pilot group remarked, "If I told her I'm putting on that condom, and she would have threw that condom, I would have rolled off." But even if a

woman refused to let him use a condom, another boy said he would finish having sex with her anyway:

> I'd say, 'I'm goin', I'm gettin' it up.' If she don't want to move, she gonna get through. Finish off and all that. If she want to leave, bye.

One woman argued that abstinence advice should supplement safer sex advice because condoms "are not 100 percent." However, most women in the focus groups approved of condom use to prevent disease transmission. An example of this endorsement is a comment by one woman after she watched the video "On the Pillow":

> Now this guy in the movie, he should have been more responsible for using the condom, if he was gonna do it. Put it on before you get there, whatever was necessary. Be ready, 'cause you don't know what you might do.
> Another woman speculated that couples often do not use condoms consistently

when one person is afraid of hurting or offending the other or when they become blinded by the heat of passion:

> Another thing I've seen, too, is most people would always say, 'Well, like they was already involved. She didn't want to get hurt. She just wanted to get him.' So the condom was just pushed aside.
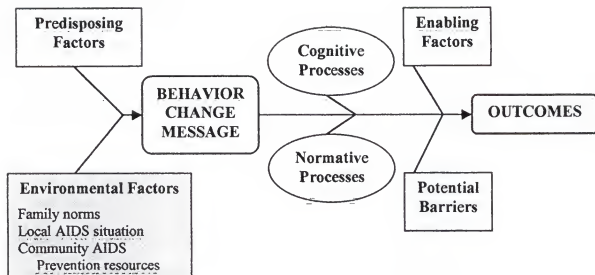
A key informant from the Task Force said she believes condoms do not provide total protection from HIV infection. She explained:

> If you knew a person was positive, you wouldn't want to use a condom with them, or nothing. I understand condoms can make it safer, but I feel like it's only going to make it safer psychologically.

Environmental Factors

Figure 17 on the following page depicts the overarching framework for this study, highlighting the environmental factors, as identified by research participants, that could influence whether individuals engage in AIDS dialogue or comply with AIDS prevention advice.

CULTURAL CONTEXT

FIGURE 17: Environmental Factors, Identified by Research Participants, that Influence AIDS Preventive Outcomes

Family Norms

A key informant from the African American AIDS Task Force said the members

of her church serve as an extended family. When an unmarried teen in the church

became pregnant, many women rallied around the girl

> All of us are God mothers, aunts. And that helps and will continue to help her
> through her hard times, through the depressed times that she will go through.
> If there is unconditional love and help, then we all can make it.

One woman pointed out that many African American youths who do not have a

mother or father in the home are part of extended families. Rather than looking to a

parent as a role model, they often choose a minister or older sibling. This situation can

lead to disappointment and loss of guidance for younger members of an extended family:

> With extended families, there's a lot of hurt. If that role model is not there, then
> you are at a loss if you can't see it and emulate it.

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Apparently, it is not unusual for an African American mother to use legal recourse as a means of punishing or threatening a man who has sex with her daughter. One boy apparently witnessed an incident in his neighborhood in which an older boy had been charged with statutory rape. His remark at the end may indicate some personal embarrassment about the event: "Her momma get mad, screamin' all over the place, and call the cops on you and arrest you. Next question, please."

For boys in the pilot group, marriage means commitment, even if the union is a common law marriage. One commented that "if you get married, you should stop just like going out there and getting with everybody." Then another added:

> That's commitment, because I figure even when they didn't have licensed
> preachers and everything, they still had marriages before God. As long as you're
> committed to this person before God, you don't need a preacher.

Most married people apparently do not practice safe sex with their spouses, either because they trust their spouses completely or because they accept the risks associated with possible infidelity. One woman argued that taking marriage vows means assuming a certain amount of risk, including the risk of HIV infection:

> That's the chance you take in life when you get married. Their life is in your
> hands, and yours is in theirs.

Local AIDS Situation

The population most likely to be diagnosed with HIV in the Gainesville area are African American women of child-bearing age, according to a Task Force leader. She said many of these women are very ill, and grandparents often must care for the patients' children.

A female pastor said she did not know how "wide range" the AIDS problem is in Gainesville, because "if it is a lot, they're just not really saying it." She added that

information about the local situation is not presented "in an open manner, where most people know that it's what we're dealing with." The only reason she personally believes AIDS is a problem in Gainesville is that she knows several AIDS patients who "say they have cancer or something else instead of AIDS."

A participant in a women's focus group commented that "right now, in our community, the fastest people that are getting it are teenagers. They just keep spreading it." Another woman commented that the local AIDS problem is not just hitting "someone who was a homosexual or whatever. It's coming to a point where it's hitting every family." Another woman commented that "the disease is so rampant that you can't ignore it. It absolutely will not go away."

One woman was familiar with the soaring rates of HIV infection in the local area because she had recently worked for a Centers for Disease Control office in a nearby city:

> We started out with hepatitis and then tuberculosis. I had seen the rates go up with AIDS, and I'm like, 'Whoa.' So I was working back there with them, and then I see it now. They interviewed people and found out they didn't know.

Apparently, Gainesville is not immune to many problems that plague urban centers around the country, including prostitution, drug trafficking, and youth living on the streets. Two key informants from the Task Force identified Porters Quarters, located in downtown Gainesville near Tumblin Creek Park, as the primary prostitution and drug trafficking area.

One key informant said she has spotted many prostitutes and drug dealers hanging out on street corners at night:

> It is in the middle of downtown, so everybody can have a piece of the action. I've seen lots of women hanging out around there. You say, 'What are you doing on the corner?' They say, 'I'm waiting for a ride.' It's a very exciting place. My church isn't far from there, so it's in a spiritually challenging neighborhood.

When you get on the other side of Fourth Street, that's where there's lots of drugs. On one side is where there's poor whites -- that's the prostitution side, and on the other side is poor blacks -- that's the drug side.

A key informant also commented that many Gainesville prostitutes face a double risk of becoming HIV infection because they sell their bodies for drugs:

You can see them walking down the street. You can see people leaning in cars, and you know they're not just giving directions. I mean, there are certain things you look at and you say, 'Hmmm . . . wonder what's going on there.' You can see a string of police cars going up and down that street, and people scatter when they see them coming. That's a real good hint that something's going on.

Another key informant said the Gainesville Police Department lacks the manpower to control the prostitutes and drug dealers, particularly after dark:

Police don't come through there nearly enough. They just let it go. They don't have enough cops, so they mainly patrol University Avenue. If you venture too far off University Avenue, you're on your own. Everything that goes on down there, goes on pretty much uninterrupted except maybe in an election year to make it look like they're taking a bite out of crime.

In the middle of Gainesville's red light district, one key informant said, is a blood plasma collection center. Although the center tests plasma for HIV, she wonders if they can catch all the infected samples:

People who are desperate for money are the ones who go there, and they'd go every day if they could. They've got an assembly line of people going in and out of there.

A male pastor commented that AIDS is a "big problem" in Gainesville because the disease is "getting out of control, and the sad part about it is that the urgency to respond to it is not where it should be. We're not seeing that it's on every billboard, but we know that it's a serious problem. There's not enough information being generated, and people are not receptive to seek out this type of information." He observed that

African American ministers in Gainesville do not place AIDS high on the pulpit agenda. Beyond the church, AIDS "is not a number one issue" in Gainesville, either:

> It may be the effects of what AIDS has done or can do has not actually hit. There are some people who have had relatives with it, so they know it's there. But it's not like if we were in a major city. Some metropolitan cities have big groups devoted to this, and hundreds of people are involved. Gainesville is an educated community, but it's not there yet.

Community AIDS Prevention Resources

The African American AIDS Task Force (AAATF) of Gainesville is a grassroots network committed to the empowerment of the African American community in controlling the spread of AIDS and reducing the stigma of the disease.

Launched in November 1994 by the North Central Florida AIDS Network (NCFAN), the Task Force has a two-fold mission: to educate the community about AIDS and to assist those who are HIV positive with the resources they need. The volunteer group meets one night a month to develop objectives and implement plans for community AIDS prevention and outreach activities. Melanie Gasper, former NCFAN executive director, stated in a memo that the AIDS network

> Understands that involving influential members of the African American community ensures that culturally sensitive decisions will be made in all phases of planning and implementation, and that in all efforts, chances for success will be improved.

The AAATF includes health care professionals, ministers, social workers, attorneys, law enforcement officers, educators, community leaders, and other citizens. Shortly after the group was launched, in-depth interviews with two key leaders reflected the "ground floor" phase of the Task Force itself and the climate of anticipation, evolution, expectation, and planning that surrounded the creative brainstorming of the group. Several organizational themes emerged from the transcripts, including goals,

momentum, evolution, inroads, outreach, community problems, and AIDS campaign plans. The Task Force has planned various projects within five sub-committees: publicity, education, faith community, client services, and testing.

The other co-founder of the group, an African American man who died of AIDS in June 1997, had developed an idea for the Task Force rooted in the belief that "African Americans need to have someone of their own to be able to talk to and bring these issues out in the open," the female co-founder said.

In planning the first meeting, an African American college administrator, the executive director of the regional AIDS network, and an African American nurse involved in AIDS care collaboratively created a list of community leaders who might be enlisted to found the new organization. In narrowing the list of names, the three women selected representatives from the religious community, educational institutions, law enforcement, the legal profession, and other areas of the community.

In a letter explaining the purpose and goals of the Task Force, the AIDS network invited 25 people to the organizational meeting. Beyond this core group of leaders, additional people from the community have participated in planning and decision making.

The Task Force includes health care professionals, ministers, social workers, attorneys, law enforcement officers, educators, and other community leaders. The membership was never limited to African Americans. A key informant explained that including people from other ethnic groups is helpful because "there are lots of people from lots of different cultures who can help us in what we're trying to accomplish."

A confidential support group for African Americans living with AIDS was founded at the same time that the Task Force was launched. According to the woman who co-founded both groups, the weekly support group only met for about a year, but in the early months had 15 regular members -- 10 living with AIDS, and five caretakers. Occasionally, the patients' children or spouses would attend also. She said the group members often listened to guest speakers or discussed "the main issues of that week, so we could meet the needs that were acute – if they weren't able to take care of their medications, if they were having problems getting their telephone deposit, housing." She said the group's HIV-positive co-founder "was very instrumental in directing them to the right persons who could help them without a whole lot of red tape or a whole lot of delay."

Given that many African Americans feel stigmatized if others know they are going to the county health department to get an HIV test, the Task Force plans to promote testing by mass producing a T-shirt that says "I was tested." In addition, most Task Force members tried to set an example by volunteering for testing. However, this modeling effort apparently failed to influence African Americans outside the group. When the Task Force set up an HIV testing site at an annual ethnic festival, the only person who participated in the testing was one of the group's leaders. Other AAATF members later speculated that the testing effort failed because the group did not attempt to disseminate testing information within the black community prior to the event.

One woman who was not a member of the Task Force speculated that the lack of community support for the organization also could be attributed to widespread denial:

The AIDS Task Force has been going on for a good while. So something is wrong. Maybe there's just not enough parents getting involved. Or maybe everybody's sitting back, still hoping it will go away.

To increase publicity for the group and its efforts, the AAATF has developed several radio public service announcements and plans to create PSAs for television as well. When the Task Force set out to develop a community awareness campaign, many members spent hours making and distributing hundreds of buttons and T-shirts depicting the group's name and logo, rather than making items that promote an AIDS prevention message. These buttons were distributed to group members and to community residents during tabling events.

A key informant said the Task Force eventually plans to initiate education efforts within the schools, but these efforts likely will be challenging because group leaders do not have a sense of how youth may respond:

Trying to figure out how receptive the youth will be to our message will be a challenge. How they respond is going to be the whole question.

During the first meeting, AAATF members brainstormed goals for educating local minority youth about AIDS:

1. Involve African American youth as peer educators.
2. Involve youth in brainstorming and developing AIDS education materials.
3. Provide AIDS education materials and curricula for Headstart and K-12 schools.
4. Create a quality, culturally sensitive AIDS prevention brochure.
5. Mobilize the churches, starting with the most progressive ministers.
6. Help reduce the stigmatization of AIDS in the African American community.
7. Select African American role models who can be trained as AIDS educators.
8. Request mission offerings at local churches.
9. Develop television and radio PSAs promoting AIDS information and services.
10. Develop a video with rap music to appeal to teens.

Another key informant said she expected the group's momentum to empower many community leaders to achieve its goals:

While we have this momentum, we want to keep it going. We also want to get us out to the public, so the public will realize that we are functioning.

A male minister said he became involved with the group because "there's a need," he likes volunteering, he has known people who have died of AIDS, and because he believes AIDS could destroy the community.

The co-founder of the Task Force said she helped launch the group in 1994 after having served as a nurse among AIDS patients for the state Department of Corrections. She said this job raised her awareness and concern because many other nurses were afraid to give medical treatment to AIDS patients, and families were not allowed to visit:

> I had gotten kind of emotional about it because in DOC, families can't come in to be with their patient who's dying. I thought, God, this is awful. If a person cannot be physically with their family, with people that love them while they were dying, we would have to find a way to show that compassion. You can't sit there and allow someone to just pass on like their life doesn't count. No matter what.

The co-founder of the Task Force said she believes the AAATF has "accomplished great things in the short time of our existence" because of "strong educated role models who show compassion and concern for our people of color" and because the group has been able to make itself visible through public relations activities.

She said the group needs to promote AIDS awareness in many more neighborhoods, churches, and organizations in the African American community before it will be truly effective in attaining its goals. Although the group has been effective in promoting AIDS prevention, the group has largely failed to provide assistance for African Americans living with AIDS, she said, and added:

> We could go in and cook a meal. We could have youth groups that would clean up their yard or take their pets for a walk on the weekend. We need to get that kind of involved – personally involved. We are very knowledgeable in the area of preventive education, and our persons are at many festivals and workshops. But when someone sees that 'I could not have done this for myself today, and you

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touched me, that means so much to me and gives me hope to live tomorrow.' That's what we need to be about.

Although many Task Force members are highly educated, they may not be in touch or concerned about the African American individuals who are most at risk or most in need, a key informant said. She added that the situation "still saddens my heart." To illustrate this point, she told the story of a young HIV-positive, African American mother from Miami, whose family did not want to care for her. The woman moved to Gainesville with her 6-month-old infant, and she did not know the HIV status of her son. She struggled financially and emotionally to take care of the baby, could not afford to pay for a phone line, and often did not have enough food for her family. During her first year in Gainesville, her preschool-aged son drowned in a sink hole. The Task Force co-founder brought the woman's tragic story to the Task Force in an attempt to initiate a fund-raising effort to provide assistance. However, when the group did not respond to the request, the other co-founder withdrew from the Task Force. Recalling the incident, the female co-founder remarked:

> You know that was such a devastating experience. We tried to bring this before the Task Force, to say this is what we're about. It didn't get off the ground. I have no idea what she received from the network, if it was anything. But it did not touch the need, with the hurt that she carried. So it's like we're creating missions as we are in places of authority, but what are we actually doing?

Message Design and Delivery

Figure 19 on the following page depicts the framework for this study, highlighting message design and delivery factors, as identified by research participants, that could encourage individuals to engage in AIDS dialogue or to comply with AIDS prevention advice.
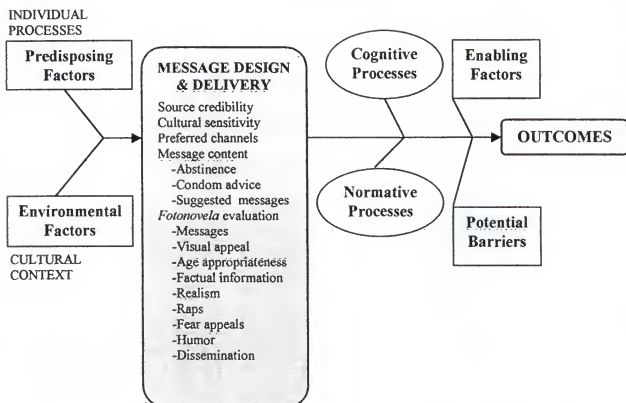
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FIGURE 19: Characteristics of AIDS Prevention Message Design and Delivery, as Identified by Research Participants

Message Content

Fotonovela messages

The *fotonovela*'s dual message of abstinence and safer sex was understood by the girls. At the end of one focus group session, one girl summarized: "The message is if you have sex, be careful." Then another girl added, "Don't have sex at all." However, when they tried to guess about what their friends might learn from the booklet, the key messages were quite different. These messages included: "Watch who they hang out with," "Watch who they call fine," and "Watch who you lay down with."

A *fotonovela* evaluator said the idea she would be most likely to remember about the story is that she could get AIDS. When asked to describe any new information they learned from the booklet, girls mentioned:

I didn't know it happens every hour.

I didn't know about the number of African American women in the Gainesville area who have AIDS.

I ain't know that a person can have HIV for 10 years or longer without knowing it.

The HIV prevention advice in the story, according to several girls, included: "Don't have sex is your safest choice," "Don't have sex if you don't have no condom," and "Don't have sex till you're in a committed marriage."

The main thing her friends learned from the booklet, one girl said, was "don't have sex until you are in a committed marriage. And if you do, protect yourself."

When asked to name the most important things they learned from the story, the boys said the two lessons were "to use a condom" and "don't do it." One boy said the new information his friends learned from the booklet was "to say no."

Sometimes the "don't do it" message was associated with protection rather than with abstinence. One boy concluded that "if you ain't got no protection, don't do it. Back off." Another boy explained that "it's like telling a person don't jump in too fast. If you gonna have sex, wait till you have a condom, then do it." One boy explained that the booklet is

> Trying to tell you to protect yourself, 'cause sometimes you don't really think about it. You just jump into it. Just jump into it. They trying to keep you from dying, but some things try to keep you from living.

One evaluator said the booklet's AIDS prevention message should be more overt. She suggested that the message say, "Abstinence is the best policy, but if you're going to have sex, have a condom."

One boy said his friends would probably learn "a lot" from the story, and another boy said the story would remind them to "watch out." However, one boy disagreed, arguing that his friends would not really learn anything because "they're gonna go out and do what they wanna do."

Factual information in the *fotonovela*

The information on the back of the booklet included "some very pertinent facts," one woman commented. "It's not overpowering them, but it's giving them the exact information that they need. Every hour, one African American child or teen dies of AIDS. That's a fact. And that's something they can identify with, and they can recall."

None of the boys wanted to change the story or its dialogue, but many wanted it to be longer by adding more information to it. Suggestions for new information, made by several boys, included an explanation of the origin of AIDS and more advice on AIDS prevention. A number of girls and boys suggested that the booklet contain "how to" instructions for condom use.

Another message that should be emphasized, one woman argued, is the fact that a person can become infected by having sex only once.

Several women commented that the booklet did not address sexually transmitted diseases other than AIDS or specific HIV infection risks such as blood contact from cuts. A news story was released from CDC the week before the second women's focus group, which reported that a woman with poor oral hygiene became HIV infected through kissing a man. A woman in the focus group keyed on this story and argued that a warning about kissing should be included in the *fotonovela*. She commented that "if you have very sensitive teeth and your gums bleed just from touching it, and you kiss

somebody with HIV, you've got it through the mouth." In light of these suggestions, one woman remarked:

> There's only so much information you can get on the pamphlet. These could be updated as new information is coming about. These sessions could continue so we can create more in-depth booklets, and we'll have more pertinent information.

One woman suggested that a contact person's phone number should be printed on the back of the booklet, and this person should be available to answer questions, address concerns, and provide additional information when people call in.

Humor in the *fotonovela*

An evaluator said the tone of the *fotonovela* was "not too serious. It what goes on. When you're talking about sex and AIDS, you want it to be funny, but yet you want to get your point across. I think it's real -- it's not too serious. It doesn't have any funny anecdotes or anything."

Most girls believed that sharing the *fotonovela* was a serious task and that the booklet itself was serious. One girl said she would tell her friends, "Don't laugh, 'cause it ain't no joke." Another girl remarked:

> If my friend want to joke about it, then I'd say, 'If you get AIDS, that's too bad.' I not gonna feel anything if she got AIDS, because she wanted to play games.

Many girls did not find the story booklet funny or otherwise humorous, but one girl did laugh about the scene in which Kevin talked about the "Mo Booty" video.

Although the girls generally did not perceive the booklet as humorous, many of their friends apparently did. One girl commented that "lots of people liked it when I showed it to them, and they laughed at the jokes, like 'that's the bottom line.' They liked the jokes very much and the people in it." In assessing their friends initial reactions to

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the booklet, one girl said one of her friends laughed, while another girl said "some laughed, some smiled."

The boys were more likely to find humor in the *fotonovela*. One boy said he thought the raps were funny, while a couple of boys said the "Don't let AIDS block your shot at life" slogan was humorous.

Suggestions for *fotonovela* stories

Various *fotonovela* stories could portray the many different ways that African Americans can become infected, one woman suggested. Both evaluators said a *fotonovela* should do more to show the perspectives of an African American person living with AIDS. She explained that a story should portray a person living with AIDS because "they may read statistics, blah, blah, blah, but if kids don't know anybody that close up, it won't affect them." The other girl also remarked:

> If someone with AIDS came up and told them they have AIDS, I believe they'd stop having sex, period. You don't want to necessarily scare them, but you want to prove to them that this stuff actually happens to kids. They want proof.

Several teens suggested that a tragic ending would make the prevention message more effective. One evaluator suggested a scenario that would show the fatal consequences of risky behavior:

> You should have -- when Tatiana is talking to Josh, and they go home and do whatever, I think somebody should get in trouble. She could say, 'I'm not that kind of person,' you know what I'm saying? But they could decide to go do something, and then after two weeks she'll get tested. She could get AIDS or pregnant.

Similarly, one boy said that he would "show them messing up. They'd probably be scared and not want to do it." But in response to this idea, another boy speculated that those readers' friends likely would "start saying they was chicken" and as a result,

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"they'd do it anyway." An evaluator suggested a similar alternative ending that also shows terrible consequences:

> You could leave Josh and Tatiana the way they are, but include the message that they do get married, but that it's too late.

Suggested messages for AIDS campaigns

The advice offered by various participants in the women's focus groups could be viewed as potential material for the construction of future AIDS prevention messages targeting African Americans. The following are a few examples of these "words of wisdom":

> You never can learn too much.
> Be careful of who you sleep with.
> Make sure you are tested before you lay down.
> It can happen to me, and I've got to cover every step.
> All it takes is to trust the wrong person.
> That one time that you take the chance could be the one that take you out.
> Never take anything for granted.
> That one you love so much could well be the person to take you out.

When asked to state the lesson of the "On the Pillow" video, one boy said, "Always wear a condom." Similarly, a boy in the pilot group summed up his advice with this statement: "It's good to wait, but if a situation happens to pop up be sure you're protected." In summing up the moral of the video, several girls issued words of warning. For example, one said, "You have to look after people and watch what you do, and be careful and use protection." Another commented, "I'd have second thoughts about doing things with people I don't know nothing about." In arguing that the video character Terrence was foolish to have cheated on his fiancee, one girl concluded, "Keep your pants zipped." Similarly, when asked what keeps kids safe from getting AIDS, one girl said, "Girls keep their shirts down."

Abstinence advice

Apparently the public schools in Gainesville do promote postponement of sexual involvement, prior to the 9th grade, as one AIDS prevention strategy. One girl recalled specific bits of advice she has received from her school teachers:

> They teach you about it, like once you get older and you want to get married, like stuff about having kids and safe sex. Like, when a boyfriend gets AIDS, 'cause by chance they were with somebody that had it.

Another girl wanted to postpone sexual involvement so that she would not be burdened with the responsibilities of early parenthood. She said she wants "to finish having time to go to the mall, going out of town, and stuff." Then one girl added:

> You need to live your childhood. I feel that you have to make a wise decision. If you did have a baby, you'd be able to support the baby. You would have a job, you would have a good living.

When one girl reflected on her own sexual decision-making, she keyed on one main issue: "I feel that if he can't wait for you, I wouldn't do it." Other girls commented that before a person begins having sexual intercourse, she should "wait till you're real ready" and be "committed to marriage." However, neither readiness nor commitment necessarily implies abstinence until marriage or monogamy.

The advice to postpone sexual involvement was not considered realistic for one girl, and she further equated abstinence with joining a convent: "If you don't wanna use condoms, it be best if you become a nun." The advice also may have a mixed meaning for some youth. One boy in the pilot group argued that waiting to have sex does not prevent HIV transmission. He remarked:

> If you had sex when you was 10 years old, or if you wouldn't have sex till you're like 40 -- you could still get AIDS. That's waiting till you're older. It don't matter about your age.

He later remarked that being abstinent will not protect people from HIV infection if they "go shoot up some needles." But another boy corrected him, saying that a person must be "abstinent from that, too!" Most girls supported sexual abstinence as the most effective way to avoid HIV infection, but several were quick to add that protection and preparation are needed, too. For example, when one girl advised that "abstinence is the best way to do it," another added, "Always be sure you're ready."

In assessing the possibilities for developing an abstinence-based campaign targeting African American teens, a key informant commented:

> I think it's a wonderful challenge, and I know it can be done. Our fight would not be with students, it would be with bureaucracy, school boards. After you master that, a lot of the students are not being taught AIDS education in the home, so the parents are willing to relinquish that duty to the church.

An abstinence message could be more effective today than in the 1980s, a key informant argued, because the decision to have sex is more knowledge-based:

> They're making choices, and the decision is that 'I choose to, or I choose not to.' Before, it was a certain amount of immaturity about their actions: 'I just want to be with him, and if he doesn't want to, I won't.' The students today are so much more intelligent. They have the knowledge given to them.

One mother said she often advises her daughters to maintain abstinence but gives them an alternative as well:

> I tell my girls, 'In the case that you cannot be wise, do not allow yourself to be placed in a position where the other person means so much more to you than your health means to you. So you have to be very strong in your decisions about what you're going to do in your sexual life.'

Another woman said that taking a public stand for abstinence is a Christian responsibility, and it can encourage youth to reach out for guidance:

> If you make that statement to a young lady or man who might not openly say, 'I want to be sexual,' they will seek you out and ask you, 'Can you help me?' If you do not open the arena further, then they're going to ask somebody else – their

friends or whatever. Then they're going to get in trouble. But if you open the arena, then later on they will call. That's what your Christian duty is.

A female pastor said abstinence is the most appropriate AIDS prevention message for youth, but "to them it's unreasonable." She added:

> I deal a lot with the kids, and it's been in one ear and out the other. I watch the little girls. They'll do anything for one of those little boys. And it don't matter how much we taught them, they'll do it. I watch stuff like that and it lets me know that there are more chances that they are going to do it than not.

The advice to wait until marriage for sexual involvement is not just reserved for teens. One church-going woman warned the single women in the focus group:

> Now, I'm sure that the ones that are single in here, that don't have husbands, the first thing you're going to be doing is like, 'Wait a minute. Before I have sex with him, I'm going to marry him.'

Several women in the focus groups lamented that despite their best efforts to discourage children from having sex, the youth still do it. One woman said:

> They've been told about AIDS. They've been told about not to trust someone and have sex -- you may get pregnant. But still yet, they're getting pregnant. And I mean, more so than they're not.

A female pastor said her teenage son recently announced that his girlfriend is pregnant. She commented that her son

> knows that sex was really made for marriage, not for couples outside of marriage and all. And he knows it's something I've talked to him since he has been big enough to talk to him about. And he hears it because Daddy preaches it. The young lady that he's been dating – she's been hearing it because my husband preaches it. I often get them to themselves and tell them why they couldn't tell that no matter how clean a person is, but still yet, she got pregnant.

In another situation, a 16-year-old virgin had sex when she sneaked away from home for the weekend. The female pastor said this "quiet young girl" pretended to be spending the weekend with a friend to go to the prom:

She and her mother are real close, and they were trying to trust her and let her go. Turned out, they went back to pick her up and found out she hadn't been there the whole weekend. The mother is constantly saying 'I don't want you to make the mistakes I made.' But even in the midst of educating her, her father is saying, 'No birth control.' And then here she is, out having sex.

One woman argued that the abstinence message is not being taught in school or at home, and as a result, no one is taking the advice seriously. She remarked that "most of them walk around with a condom, and that's it – 'cover myself so I won't get it.'" An important component of an abstinence message, she said, is the idea that it is OK to be a virgin. She suggested this approach because many virgin teens feel out of place and "don't want anyone to know that they're a virgin."

A male minister said he is not afraid to preach about sex outside of marriage, even though "lots of folk don't." In his talks with youth and Sunday morning sermons, he teaches an abstinence message emphasizing that

> if they play around, have casual sex, it can be traumatic in the long run, whether it be AIDS or pregnancy or something else. The Bible lets us know that sex outside of marriage is taboo, it's wrong. You want to keep yourself for your husband-to-be or your wife-to-be. It's something special that you want to hold onto.

The main reason youth should postpone sexual involvement, this minister argued, is that "it's not the right timing." He said youth are not mentally ready for sex, and he often advises them that the consequences of sex

> Could set you back 10 years. Put all your goals in front of you – you've got college, you've got med school, you want to be a professional. You don't have time, if you go out and commit fornication, to get a baby early or pick up a venereal disease. That can be traumatic and throw your whole life off.

Another reason, he tells them, is that sex can ruin the enjoyment of youth:

> You've got to remember that you're still trying to enjoy those young years, and you don't want all these other things pulling at you and adding to the frustrations of your life. You have a few ups and downs, but life should be enjoyable.

The minister said one of his sermons about abstinence focused on Proverbs 3:5-6, which states: "Trust in the Lord with all your heart and lean not on your own understanding. In all your ways acknowledge Him, and He will make your paths straight." The minister said this scripture provides a rationale for postponing sexual involvement:

> You believe God for everything, and you know that He has your best interests in mind, and that everything's under control. He's going to supply all of your needs, so there will be no need for you to actually go out and make things happen for yourself. If I'm a person who figures 'Well, God's not moving fast enough for me,' or 'Things are not happening, and I'm not finding the right person that I really want to marry' – if you don't trust the Lord, you'll put your trust or confidence in someone else, and you'll find yourself running behind something that won't ever be yours. Then you can find yourself in some predicaments where you're being used, taken advantage of, because you're vulnerable.

Controversial condom advice

While the church is expected to uphold Biblical principles of sexual purity, it also is supposed to extend compassion to sinners, according to their needs. The dilemma over whether to recommend condoms as safer sex advice highlights this moral conflict because failure to help individuals protect themselves could result in AIDS deaths. One male pastor observed that most African American churches in Gainesville "won't go along with the condom issue, so they'll stress abstinence or they'll stress safe sex." He agreed with this approach, saying, "That's just the way it would be, according to the Bible." He also said he will not promote condom use in his church because that advice would condone premarital sex, which is a sin:

> I probably would not tell anyone that 'Well, if you're going to have sex, use a condom or birth control pills.' I would have a problem telling them that. That's like saying, 'Here, go ahead and do as much as you want.' The message I really want to get over to them is 'Keep yourselves. Don't destroy your young lives. You can wait. I know there's some pressures.'

Several women disagreed with this stance, arguing that the church should not condemn safer sex advice. Although promoting condom use may endorse sexual sin, one woman confronted this dilemma by remarking that "we're walking a fine line, and the fine line is we like compassion." Another woman explained her position this way:

> You're not saying it's OK. You're just realizing that these kids are human just like us. Some of them are going to try it. So the best thing to do is teach them abstinence, but don't be foolish enough not to teach them what to do after abstinence. I know a whole lot of young ladies, and they'll come and tell me, 'Yes, I am already having sex. Yes, I am doing it every day with someone.' So what do you tell them after that? You have to tell them how to protect themselves.

When the boys were asked what kind of advice they might give to a friend who wants to become sexually active, one said he'd encourage the friend to have sex but warn him to use protection: "Take it, buddy. Take it. You need to be protected." Another disagreed, saying that he would advise his friend to be more cautious: "I'd say don't do it. Man, I'd be like, 'Watch your thing.' I'd be like, 'You should think about what you're gonna do before.'" One boy argued that giving abstinence advice might not persuade a friend to postpone sexual involvement. He commented, "You can't tell somebody not to get it."

The church has a utilitarian obligation to help its weaker members avoid trouble by offering realistic alternatives to Biblical mandates. One woman argued that Christians should "help the whole" by reaching out to those who cannot comply with abstinence advice:

> In helping the whole, there may be one who will not be able to maintain, and we need to be a help to that person. We need to be there with loving arms and unconditional love. If you cannot maintain, we need to talk to you about keeping you healthy and safe. If you choose to indulge in sexual behavior, you need to protect yourself. For those that will not be strong, we have a responsibility to

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make sure they know how to keep themselves safe and understand the consequences of their actions.

When talking to her own children about sex, a female pastor said she gives them

conditional abstinence advice:

> I tell them, 'I'm not crazy. I've been there where you're at. And even though I want you to not have sex, and I want you to get married and do it the way you're supposed to do it, I am going to give you another option. If you happen to do this, use a condom.' And people are like, 'You did that?' 'Yes.' Because I feel like anything else is stupid. I really do.

She argued that parents should provide condoms and safer sex advice when they

are suspicious about a teen's behavior:

> To me, it's stupid if you know the child is showing you all the signs that they're going to do it and you're gonna tell them they shouldn't. I feel like because they make a mistake it shouldn't be something that's gonna take their life.

The pastor also believes it is morally defensible to advise youth to use condoms, but she

does not talk about condom use in public settings because she must fulfill a pastor's role

in a conservative church:

> I mean, I wouldn't get up in front of a church and just say that. But when I'm doing individual counseling and stuff, I try to tell them that because, I mean, there's just so many situations that I get to see that a lot of Christians don't get to see. It's not a compromise for you to tell them that they need to be aware that if they have sex and they're not protected, it's not that you just get pregnant. You get AIDS. I feel like that's not against God's rule, because He always teaches us what to do. But then He also shows us that He has love and forgiveness. He knew that there was gonna be that place where people were not going to be absolutely true to what they are supposed to be.

The teen focus groups were conducted as part of a church-based summer youth

program. The director said she set up the program to be funded and operated as a

community services program so that youth leaders could have the freedom to discuss

sensitive issues such as condom use in ways that might not be acceptable in a more

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traditional church setting. She commented that in planning summer activities for the youth:

> Any program we do doesn't have to be based on what our religious beliefs are. We're not going to do it in church, but we can do it through this program. We're dealing with church kids, so we need to say abstinence first because they need to know, OK, this is the church's background. But, you know, if for some reason it's more possible than the abstinence, we can do that.

Visual appeal of the *fotonovela*

Among both the girls and boys, the major criticism of the booklet's appearance was lack of color. One girl commented, "I'd like it better if it wasn't all black and white." Another girl commented, "We need some color."

The boys tended to be more candid in their evaluations of the *fotonovela*'s appearance. One remarked that "it's ugly. You need to get a new color." Another boy agreed, commenting that "it's black and white through the whole pictures, and they look grayish." One boy suggested that "green would be a good color." Although most boys thought the photos otherwise looked acceptable, one boy argued that the booklet would fail to draw attention unless it contained color:

> You're telling kids how to protect themselves by showing them this book. Why would kids want to read it if it don't got no color to it?

One boy argued that even without color, the *fotonovela* was effective because "it shows kids what's going on." However, another boy said the booklet should do more to "show them how you catch AIDS." One boy said he wanted "to see some action," while another boy wanted to "make it more exciting."

None of the girls objected to the size of the booklet. Most boys, however, thought the booklet was too short and small. Many repeated this criticism throughout the evaluation group session. For example, one boy commented, "But see, they only got four

strips in here. They need to have more than that." A conversation among the boys highlighted their thoughts about the booklet size:

> Boy 1: You could add more pages. Like cut it bigger, so you can put more information in it.
>
> Boy 2: Yeah. I thought it was gonna be, like, big.
>
> Boy 3: If you're gonna have it front and back, you could at least have some pages to it. And more information.
>
> Boy 1: You need to have lots of information, and lots of color pictures and stuff, so you will know what's going on.

The girls were pleased with the type size and style of the booklet's lettering. One girl recalled that her friends "said it was neat looking." Another girl commented that "it looks neat and pretty."

The boys were more critical of the lettering. One commented that "they look straight," while another suggested that "for the title, make it neater, make it stylin'." One boy did not like the way the photos and script was placed on the panels and suggested that we "make the book neater."

Fotonovela **photography evaluation**

Most girls said the photography was their favorite aspect of the booklet. The girls said they liked the photos for a variety of reasons -- because they were funny, realistic, or simply "'cause they go with the words."

The favorite photo, among both the boys and girls, was the picture of two boys, with one holding condoms and the other holding a video box for a pornography movie titled "Mo Booty." Referring to this photo, one boy remarked that "there was just one picture where it shows you the true meaning of AIDS – what to do and what not to do."

Another boy explained that this photo was his favorite because it symbolically shows boys how to protect themselves:

> I really like that video and the condoms, showing them, because they're what you've got to use for protection. It's not just showing you a woman, it's showing you condoms. Suppose a woman had AIDS, and you wanted to have sex with her. They got condoms, so you have the protection you need.

One boy said all his friends liked the booklet, and the aspect they liked best "was when they was playing basketball, and when they was holding up the video," one boy remarked.

When the photos were being taken for the "Mo Booty" scene, in which one boy was showing condoms to his friend, four other boys were hanging out nearby and asked to look at the condoms. The boy who was not holding the condoms in the photo became upset because he wanted to be the one shown holding them. After the photos were taken, the boys went inside except the boy who was shown holding the condoms. As soon as the other boys were out of earshot, he asked if he could keep a couple of the condoms for himself, then quickly tucked them into his pocket. Apparently, he did not take the condoms to impress his friends, or possibly he feared getting into trouble with the adults who ran the summer youth program given that it was church sponsored.

One girl said her friends were "more interested in the pictures" than the story or AIDS facts. She added that "they were picking about their hair and stuff like that."

Interest in the photos may have promoted discussion about the booklet and its issues, however. Many of the girls' friends were inquisitive because they recognized some of the teens in the photos. One girl remarked that her friends "asked like, 'Who are the actors?' They seen the pictures that were funny and they like 'Who is this?' Then they asked me some questions after that."

A few girls who were self-conscious about having their photos shown in the booklet still reacted positively to the booklet. They were most concerned about not looking pretty or about being shown with boys. When asked what she thought was the worst thing about the booklet, one girl simply said, "Me." Then she went on to say:

> I like the pictures. I just don't like my picture. I don't like the one with me on it 'cause I look all swollen. If I looked pretty on it, I'd like it better.

Another girl pointed out, "Clarissa, there's your belly." Then another remarked, "I look like I had some drugs." When asked to tell what she thought was the most important thing she learned from the story, one girl said, "Not to take a picture with no boys." One girl commented that when the boys see the booklet, they would probably "be like, 'Ooh, I don't want to take no picture with that person.'"

When the teens were photographed for the *fotonovela*, one boy objected to sitting next to the girl who played Tatiana's part. Even after his friends insisted that he sit next to her just for a quick photo, he refused to sit within three feet of the girl. After the booklet was published, a girl in a focus group remarked to the girl who played Tatiana: "It's like you got AIDS. He don't want to be beside you."

Concerned about her mother being upset about sexual dialogue being linked to her photo, one girl remarked that "It sounds stupid, 'I'm gonna make you feel so good.' I ain't talking about the pictures. I'm gonna get in trouble when my mom sees it." At one point during the focus group session, this girl interrupted the discussion and announced, "All right, y'all. Don't show anybody." She said she feared her boyfriend or her mother might see the photos of her sitting next to another boy and jump to the conclusion that the situations described in the story had actually happened.

Source credibility

The influence and credibility of the African American church is rooted in the oral tradition within extended families, argued Jean Tapscott of the national Agency for HIV/AIDS. As an African American who has served 11 years as an agency administrator, she has observed that the church plays a major role in the black community because "the older people are moral teachers who can pass on information in the home, to their kids and grandkids, nieces, and nephews."

Tapscott's agency has developed AIDS intervention strategies for African American churches that utilize this cultural norm. She explained that "we have a saying, 'Each one, teach one.' Using AIDS literature and workshops, we are teaching church members to teach others. The church's credibility is the entire issue."

A male, African American minister in Gainesville acknowledged that his church members look up to him for guidance. He remarked:

> Ministers and those in authority are looked at in a certain light, and there are things that people will respect when it's coming from them, as being like gospel. I think there's a lot of credibility behind that role as a minister.

He further asserted that trust is a key component of credibility, especially parental credibility:

> If kids feel that they can't come and talk to you about those real sensitive things they're going through, they won't see you as a trusted person. One of the beauties of having children is when you get to know them, they get to know you, and they trust you and feel comfortable talking about the things that are happening in their little lives.

In discussing how their parents talk about sex or AIDS, a conversation among boys in the pilot group revealed that parents do not always have high credibility in dealing with these issues:

Boy 1: They need help.

Boy 2: They like, 'You go around much with that girl, you're gonna catch something, messing around.'

Boy 3: And like, 'If she ain't very easy, you won't catch no AIDS.'

Boy 2: They like freak if they catch you doin' it on the sly.

Many AIDS PSAs on television, one woman argued, use adults rather than teens as spokespersons. She remarked that using teens as sources is "a big start, I would say. Because when the kids do it they say, 'Wait a minute. This is someone I know.'" One woman said she first learned about AIDS from famous African American male spokesmen on television. She remarked:

I think mine came through television, mostly with the tennis guy, Arthur Ashe. He was one of the ones that I heard about that contracted it back in the 80's, and then Magic Johnson and Ezy-E and Rock Hudson and all these guys came along. It became more popular. Then, you started seeing it in big, bold letters.

In response to this comment, one woman asked, "Were most of those gays?" and another woman remarked that, "They were just messing around." However, a woman in another group viewed these men as heroes:

Like that Ezy-E, one of the kids' favorite rap stars, Rock Hudson, different people like that we watch on TV – we see those people, and those are our heroes.

The women also appeared to hold high respect for Magic Johnson as an AIDS spokesman. One woman commented:

I think by him announcing that he had AIDS and getting off the team to protect the guys on the team and the other players, he did something that most people wouldn't do. He started when American people started really focusing on AIDS, and children when he went around to different schools and different things. I think he made a step that opened up more information concerning AIDS.

Another woman pointed out that "children are more apt to listen to him because they like him, and he's been a public figure for such a long time. He had a commitment and made a mistake. And that mistake cost him his future, his career."

When asked what she thought of Magic Johnson, one girl indicated that he was highly credible in her eyes: "If I saw him on TV, I'd listen to him, and I'd probably think about his experiences and perspectives." Another added that she thinks Johnson is "still all right, even though he have AIDS or HIV."

One girl knew that Johnson contracted HIV when "he cheated on his wife" and that his wife "ain't got no AIDS." A boy in the pilot group mentioned Magic Johnson as an example of someone who was infected for many years before he discovered it. In response, another boy remarked, "I would not play professional basketball with that man."

Given that the other boys focus group was conducted the day after the Tyson-Holyfield boxing incident, many expressed concern that Holyfield's ear injury may have exposed him to HIV if Tyson were already infected with the virus. In light of the recency and sensationalism of this event, the boys were far less interested in talking about Magic Johnson than the boxing melee. However, one boy did say that Johnson no longer has AIDS. His comment may be consistent with the view among many African Americans that Johnson is able to pay for superior AIDS treatments that are financially out of reach for most other HIV-positive individuals.

Similarly, Johnson was seen by several girls and women as a wealthy man who can afford AIDS treatment that others cannot afford. One girl commented:

There are medicines that really help, but the regular day person working at a teacher's salary couldn't afford that. I know who could afford it is Magic Johnson, and he gets his shots or whatever.

While boys may not be influenced by Magic Johnson, many may view other basketball stars as their heroes. One woman said her 13-year-old son looks up to many African American basketball players, especially Michael Jordan and Scotty Pippen. The boy also admires many rap stars. The woman wants her children to evaluate the behind-the-scenes lifestyles of celebrity heroes to decide whether these men are really worthy of respect. She advises her son:

'Even if you choose Ezy-E, even if they talk about non-violence, it's not a responsible lifestyle. When you see these men as your role models, make the distinction about what goes on in their life, around them, and how they carry themselves. You can rap, but when you're 30 years old, you'd be back out here on the street without a job, 'cause rap would be faded out by then.

The woman said that Michael Jordan and Scotty Pippen are worthy of respect because they have returned to the black community to provide educational mentoring for children and financial assistance to schools. She commented:

They don't forget the people that they've left behind. That's the type of role model figure that you want to become. You have to emulate those values. You don't see very many of them telling you, 'Oh, Dennis Rodman is the man.' He can do what he wants to do, and that's good, but there has to be a drawing line.

Cultural sensitivity

The extent that an AIDS prevention campaign is sensitive in addressing cultural norms and controversies among African Americans may predict the extent that it effectively targets the intended audience. One key informant from the Task Force argued that most religious AIDS prevention materials do not effectively target African Americans because they are developed by and for whites:

When I see the AIDS messages on TV, especially the ones portraying white people, I think that white churches might deal with these kinds of issues

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differently than a black church would. You say one word that can mean something else. We'd say something's 'bad' when it means something's 'good.'

A male pastor commented that AIDS prevention information should be tailored to address stigma among African Americans. He commented:

It's something that you can't just limit to one community, but at the same time, we know that education needs to address all the little typical things that the African American community has thought, like the stigmatism of people who have AIDS and homosexuals and drug users and a whole lot of other people.

Street language should be a primary component of an AIDS prevention message targeting African American youth, one key informant suggested. For example, the common use of the slang word "jump" was heard in discussions among both boys and women during the focus group discussions. After watching the "On the Pillow" video, one woman said Terrence "took her back to his place from the jump." One boy said that "jumping into it" is "like what happened in that movie, like if you want to get with somebody's girlfriend."

Picha hadisi

In this study, a *fotonovela* was adapted for African American teens, whereas in the past this channel has been used to target only Hispanic individuals.

Since the word *fotonovela* likely is unfamiliar to most African American teens and adults, an alternative label may be needed for this audience. In the focus groups, the moderators referred to the *fotonovela* as a "story booklet." In the course of discussions, one girl called it a "picture book" and another girl remarked that "it's a play."

One member of the African American AIDS Task Force suggested that the word *fotonovela*, Spanish for "photo novel," be translated into Swahili. She suggested this approach to coordinate with the primary AIDS brochure used by the task force, titled "*Umoja Sasa*," which is Swahili for "unity now." The Swahili translation for "photo

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novel" is "*picha hadisi.*" Perhaps in the future, *picha hadisi* could be used as a name for photo stories designed by and for African Americans.

Raps

The raps were especially popular among both girls and boys. The girls liked the raps for different reasons. One remarked that "it's neat," and another pointed out that a rap "makes it stick in your head." When one girl mentioned that she liked the rap titled "A limit to a lime," several other girls joined in and recited the rap with her.

Several teens said they especially liked the raps because the lines rhymed. One of the *fotonovela* evaluators said the raps were interesting, and she explained that a rap is "just like poetry. That's all it is -- just poetry, and then they add a beat to it."

During the youth focus groups, occasionally a participant would interrupt the discussion just to recite a line or phrase from the booklet. The one most frequently mentioned was the end of the first rap: "That's the bottom line." One girl used that line to talk about her own life: "I ain't gonna do nothin' and that's the bottom line." Then another girl repeated, "And that's the bottom line." The most quoted line among the boys was "Don't let AIDS block your shot at life." An evaluator said she especially liked the line that said, "So watch what boy or girl you call fine."

Among the girls' friends, the raps and the "steppin'" were favorite items in the booklet. One girl said her friends thought the raps were "fun." In the late afternoons, while the boys went to the church parking lot to shoot hoops, most of the girls would line up on the sidewalks to rehearse their collaboratively choreographed "steps," and every day they would add another move. These "step shows" included coordinated clapping, shuffling, stomping, and dancing in circles or lines, but usually no singing, music, or

words except occasional counting or other verbal instructions. Sometimes the girls created steps to go with rhythmic music on a cassette tape, or their friends would sing repetitive, original, unaccompanied songs while the steppers performed.

The use of raps in the *fotonovela* may have been attractive to many teens because they had access to the written version of raps in a culture where raps are usually shared and taught orally. After the skit writing workshop, conducted on the first day, several individual boys and girls jumped up to recite the rap in front of the entire group. On a couple of occasions, one boy openly criticized the ones who were reading the raps.

Another boy scolded him, saying, "You're just jealous." Several boys in the youth group were also members of a rap team that sometimes performed in church. One youth leader explained that the younger boys who do not know how to rap are especially envious of the ones who can.

The raps in the back of the *fotonovela* are intended to be simple and easy to read, which could enable even inexperienced rappers to impress their friends. For example, when asked what he thought of the raps in the booklet, one boy said, "This rap? I can do that." Another boy said using raps "helps make the book sound better."

When the teens in the summer youth program were asked to write a skit or play about AIDS, all the boys chose to write raps instead. Unlike the girls, who usually wanted to write skits collaboratively, the boys wrote their rap verses individually and did not want their friends to see their raps until they were finished.

Unlike the boys in the summer youth program, who exclusively wrote raps, the boys in the pilot group were intensely focused in writing collaborative skits with other boys. In the pilot group, the boys worked in groups of three or four and typically

produced skits that were much more serious, morbid, and streetwise than the ones created by the girls in the pilot group. Although the differences in writing preferences between the boys in the pilot group and the summer youth group could be partly explained by socioeconomic differences, the primary explanation may be the fact that most boys in the pilot group had experience in performing various pre-written skits for radio spots. In critiquing one of the raps, one girl commented:

> I don't like that part about respecting AIDS. You could say something, like that you're aware of it or something. Like 'AIDS won't take me 'cause I know all about it.'

An evaluator criticized the Scriptural implications of the first line of the rap titled "The bottom line." She commented that "it says, 'They say sex is wrong, sex is not right.' But the Bible says there's nothing wrong with sex, if you're married."

Preferred channels

The African American teens in the focus groups named a variety of media channels they would like to use to learn more about AIDS. The girls suggested that other effective channels for AIDS education might include television or radio commercials, movies, and cartoons. A woman recalled seeing an AIDS prevention cartoon on local television that was developed by older teens to reach younger teens. She remarked that the cartoon

> Had a lot of effect because it's entertaining but it made the point, and it was very understandable. This cartoon got their attention.

One girl suggested a television mini-series because "that's something you can watch with your family." A woman argued that movies, educational videos, and television spots "really do help a lot." She observed that on television, "they're beginning to really educate people more with showing the effects and stages. I mean, I

would really like to see more videos like that." A boy said he has learned about AIDS by watching movies. He commented:

> I know a lot about AIDS. I keep watching videos. Somebody have sex, and every time after that, they say something about AIDS.

Occasionally, teens made comments reflecting their awareness of educational techniques used within traditional health communication campaigns. When asked how they might make an AIDS awareness video, one girl commented that "probably at the end, they might have a message with all the people in the cast saying it, something like safe sex." Another girl added that "they'd probably tell the amount of people who have AIDS, in the millions."

Several boys recommended that AIDS testing could serve as an effective education tool among African American teens. While testing itself is not a channel, it provides an opportunity to educate individuals using interpersonal counseling, pamphlets, or videos.

Fotonovela vs. traditional media

Although most focus group participants were aware of tools and strategies used in traditional AIDS prevention campaigns, some believed past approaches have not been effective in changing behavior. Pessimism about traditional strategies, however, might prompt a positive reaction to a novel strategy such as a *fotonovela* intervention. For example one woman observed:

> If you look, the pregnancy rate is going up instead of down, so we still must not be doing enough. Sometimes we just have to change the way we're doing things, and re-strategize so that we can reach them. Because right now, it's not helping.

Another woman observed that the *fotonovela* is different from traditional AIDS prevention campaign materials because "it's real children. That's what they're going to

relate to. It's not that parent on the television that they always show." The *fotonovela* is more attention getting, another woman argued, because the message is presented by and for teens, rather than by adults. She observed that if

> A grown person's telling them something, sometimes they'll rebel. This is the whole thing I like about the pamphlet. Because children, they can relate only one on one with another child. It's the kids' point of view. It may not fully get all of them attention, but it will get somebody's attention.

One woman enthusiastically supported the strategy of having teens collaboratively create AIDS education materials for their peers. She remarked that "when you have teen kids coming together, they team up with some of the best ideas you ever want to imagine."

Another woman observed that the *fotonovela* project is similar to a youth newsletter project in her church. All teens are asked to contribute material to the newsletter, and the pamphlet is distributed during church every Sunday. She explained:

> Some of them just write their name. They're like, 'Oh, we know these kids. This is what they think.' It's about anything they've went through, about things they have to deal with personally. It's like, 'This could really happen 'cause I know this person.' And it makes them wake up. A lot of kids want to pray or come forward right after testimony.

A couple of the girls thought the booklet did not contain enough information because it contained so many photos instead. This evaluation could have been based on their comparison of the *fotonovela* with traditional AIDS brochures they may have seen in the past. For example, one girl remarked that the booklet "ain't nothing but pictures."

One woman observed that the length of the *fotonovela* made it unique, when compared to other kinds of AIDS prevention materials. She remarked that "even in its brevity, it was different."

A *fotonovela* evaluator said the booklet should offer more statistics and other information because "I see a lot of things like that." One boy suggested the *fotonovela* should have a video to go with it. Another boy suggested that the *fotonovela* be modified so that it more closely resembles a traditional AIDS prevention brochure. He explained:

> For the beginning, they could have put 'How to prevent AIDS.' And then, have like pictures of people in color pictures, and have like a longer strip.

The perceived need for more condom information may be based on a comparison of the *fotonovela* with traditional AIDS brochures or materials used in the school curriculum. For example, one girl commented, "Oh, everybody think people need to know more about condoms." One boy said he wanted to see more pictures of condoms in the booklet and complained that "they only got three, four condoms on the book." Another boy suggested that a condom be given out with the booklet.

Future dissemination of *fotonovelas*

When asked to suggest some ideas for future distribution of the *fotonovela*, the girls group came up with a number of strategies: mailing them to people who request them, placing one in every mailbox, mass mailings, handing them out in stores and other public places, and distributing them in the schools. One boy also recommended distribution in the schools, suggesting that "you need to give the teachers at school like a lot."

Specific distribution strategies, as suggested by the women, included placing the booklets in pediatrics waiting rooms and distributing them to employees of various offices, stores, companies and other businesses. Many women said they liked the accompanying sheet that provided tips for sharing the booklet with teens and

recommended that this sheet be included with the booklet when distributed to adults. The possibilities for sharing the booklets are numerous. One woman commented:

> You could go so many ways with this. You know, how sometimes you go to the pool, and you see kids talking to the boys, 'cause they have like after-school pool things. You could use that. You could be like, 'OK, now, You see this thing? Go over here and read this.'

Although some ministers likely would be reluctant to take an official role in promoting the booklet in their churches, several women recommended that the booklets and accompanying materials be distributed to church youth leaders first. One woman commented:

> Maybe where the pastor may not deal with it or whatever, a lot of them have youth leaders who do a lot with youth, and they know where the youth are. So they know how important it is to get out this information.

Several women recommended that the booklets be distributed to adults before they are given to teens and that the adults be trained in how to discuss AIDS and sexuality issues with their children. Another agreed with this suggestion, and added:

> It's easy to give them to the kids if you take them to school, but you should get the adults to introduce them to the children.

A valuable aspect of the booklet, one woman argued, is that it can open a door for conversation between a parent and child after the parent receives in-depth and current information about AIDS in a workshop setting. She explained:

> The parent gets the information in a class and furthers herself in the knowledge of what's going on and about the disease itself. When she does, when her child comes to her and asks different questions, she'll have the ammunition to answer these questions.

Another woman recommended that adults organize groups of teens to "start going out into the neighborhoods" to initiate discussions about AIDS and other health risks.

She plans to organize a boys' discussion group in a low-income housing area and to promote the event with fliers, refreshments, and door prizes:

> I'd be willing to talk to the boys about any sexual thing they like. We really need to sit down and have a group session to teach them about these diseases.

Cognitive Processes

Figure 19 below depicts the overarching framework for this study, highlighting the cognitive processes, as identified by research participants, that help explain how individuals engage in AIDS dialogue or comply with AIDS prevention advice.
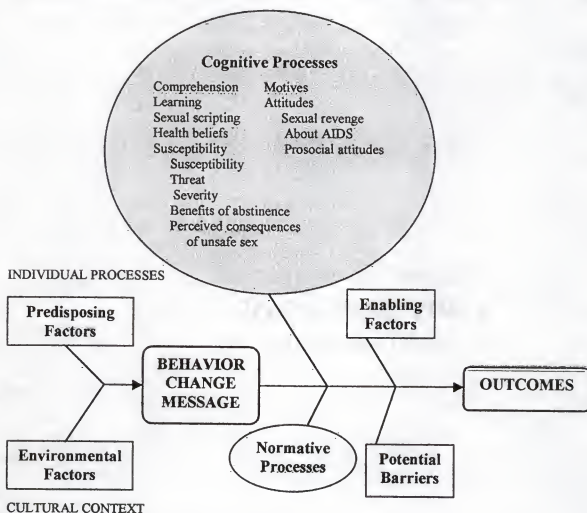

FIGURE 19: Cognitive Processes, Identified by Research Participants, that Influence Individual AIDS Preventive Behavior

Reading comprehension of the *fotonovela*

All the teens agreed that the booklet was readable, and none said it was difficult to read. One girl commented that "it's not too much reading." Another girl remarked, "There ain't no hard parts in here." A boy observed that "it made good sense."

One woman commented that the booklet is "not too long" and is "simple to read." Another woman remarked that "it's not no big long article or something that people don't have time to look at." Similarly, a *fotonovela* evaluator said the booklet was easy to read and added, "I mean for middle school age, it's really easy."

In critiquing the language, one evaluator said use of the word "porn" was confusing because it was a bit unfamiliar and at first, she "thought it said 'popcorn,' or something." Another evaluator said the word "flick" is familiar, but "we use the word 'flick,' you know, like those disgusting movies at the video store." She suggested that a more neutral term would be "movie" or "video."

Apparently, one girl did not have sufficient reading skills to comprehend the *fotonovela* script. Throughout the focus group, she asked other girls to tell her what the characters in the booklet were doing. Outside the room where the girls' group was meeting, a youth group worker commented that this particular girl was unable to read because of a learning disability. After the focus group session, the girl demonstrated her interest in learning about AIDS by using colored markers to make a poster that simply contained the word "HIV."

Learning about prevention

Apparently, many African American youths are attentive to abstinence advice and knowledgeable about the consequences of sex, but they do not follow this advice. One woman remarked about the evidence of their risky behaviors:

> To me, pregnancy and all that kind of stuff -- your teacher tells them, 'Don't have sex.' They listen, and they go have more babies, even though they're learning.

Another woman complained that AIDS prevention advice for youth usually "goes over their heads, just like everything else." Photos, videos, or cartoons may be essential components of any AIDS prevention intervention targeting African American youth because these visual elements can stimulate attention, involvement, and learning. One woman commented

> We can tell them 'till they're green. They hear it, but until you see it visually, it doesn't really affect you. I think the young people, even middle school age, need to see videos on AIDS and find out what it is.

The "On the Pillow" video used for focus group discussions apparently made a lasting impression on many boys. Even during a focus group session held two weeks after the video was shown, the boys frequently volunteered remarks about scenarios portrayed in the video, in light of various discussions. The main points they recalled, long term, included Terrence's rationalization that having sex with a stranger is OK because Crystal was "a fine woman," that she deliberately infected him, and that he caught HIV from her because he did not insist on using a condom.

Another woman noted that "some of them don't comprehend it just from talking about it. Some of them are visual people. You've got to show it to them."

After watching the video, one woman said she liked it "because it was more revealing about what's going on in the world." A girl endorsed the video as an effective

learning tool: "I think they should go play the video 'cause kids will come back to it and remember it."

Although visually showing how a person can become infected could be disturbing to some, it may be the most effective educational strategy. One woman commented:

> It may seem like it was going into something too much, but just to get the picture where it could be realistic enough to make you know that this is how it happens.

When asked to guess how her own church might make a video about drug awareness, one girl said the video probably "would show people who take drugs and have HIV."

Sexual scripting

The way that teens conceptualize sexual action sequences, including their strategies for requesting sex and refusing sexual advances, can reveal important aspects of communication barriers to practicing safer sex. The sexual scripts embedded in the comments of youth focus group participants may reflect both popular and prescriptive norms of behavior among African American teens.

Apparently, many boys believe they are expected to initiate sexual activity with girls and to provide protection such as condoms. Some boys expect their advances to be seen as sexual harassment. For example, one boy commented:

> When your friends go out and sexual harass somebody, before they do anything, like you could talk to them about using a condom.

Although the sexual norm may be for boys to initiate sexual involvement with girls, the girls often may be the aggressors. A *fotonovela* evaluator recalled a role-playing exercise at school, in which a guest speaker asked the girls to act as "the aggressive ones." She said the boys "were like, 'I don't want to do it.' It was funny."

One woman said young girls constantly pursue her sons by calling her house until 3 a.m. She remarked that these girls "are trying to get to the boys, every kind of way they can, anything they can do." She recounted one story of how two teen sisters aggressively chased her sons, despite the girls' religious upbringing:

> Their mother was very strict on them as far as raising them up right, teaching everything they needed to know. I knew this mother put everything that she could into them. As soon as they hit a certain age, 12 or younger, the next thing I knew, they were having sex. And the reason why, I found out, was 'cause I had boys. My son says, 'Momma, see you always talkin' about that's such good little girl. But you don't know. I've already had sex with her.'

Shocked at this story, another woman exclaimed, "I'd hit the floor!"

Rape may be perceived as a particular problem and risk factor among many African American men. One boy commented that "date rape, raping a girl – white people don't do that that much, 'cause they know how to protect themselves."

When asked, "How do you decide how far to go with a girl?" one boy in the pilot group responded, "As far as they let me." One 13-year-old boy bragged about a hypothetical sexual encounter when asked what he thought about waiting until marriage to begin having sex. He remarked, "Even though I believe in waiting until marriage, if a girl come up to me and asked me, I'd go up in her."

After watching the "On the Pillow" video, one boy said he would probably jump at the chance to sleep with an attractive woman: "If a lady came in, I'd do the same thing. But I'd have a condom on."

The boys pilot group was asked, "How long do you think it takes before it's cool to ask a girl to have sex?" One boy said he would probably wait a week. To this, another boy reacted with surprise: "A week? Boy, you gonna get dry." Then another warned, "Boy, you gonna give her occasion."

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A week would not be sufficient for one girl, who remarked, "I feel like you don't know nobody in a day, not even in a month." If a boy pressured her to have sex after three months, another girl said she would tell him, "Don't worry about me, 'cause three months is not enough time to know somebody."

When asked how someone can know if they are ready to have sex, various boys said a person is ready when "they're in love with that person," when they are willing to accept responsibility for a possible pregnancy, "when it meets your needs," when "it's common sense that comes to you," when "it's just a stage that I reach," or "when you get married."

When the boys in the pilot group were asked the same question, one boy responded, "Oh, we ready." A boy in the pilot group said he would be in love enough to have sex "when it comes and it's not just a feeling, but it's like the person. The feeling is good, when you kiss that person." Another boy said that a person should wait until marriage to have sex, but he further explained:

> At a point in time, it so happens to come up, when you like, you can't get out of it. It's too stone cold clump (pounds his fist on his hand), and you hot, you cannot get out of it, all right? You just drag yo up shot straight. You show you's a man, and you go out and drink. You go see a fine girl. You know the only way you get off, is you protect yourself. But I believe you wait until you get married.

Although the traditional sexual script for adolescent boys may be to pursue sexual relations at every opportunity, the boys in the focus group reacted differently when they thought about a woman pursuing them instead. Each of the boys was asked to contemplate what he might do if a 20-year-old woman approached him at a concert and asked him to go home with her. One boy said he'd probably look for a place to hide or an escape route:

The bathroom's got those booth things. So I'd say I have to use the bathroom. When I come back out, I'd be trying to don't talk to her, and I'd just walk out of that room. You know what I'm saying?

Another boy said he'd go home with the woman, but try to limit their interaction to just talk and no sex: "We don't have to have sex, but I'd try to talk to her about what she thinks about school and things like that. That's the bottom line."

The sexual scripts among African American adults may not be much different than those for teens. Apparently, many African American men and women have a reputation for "trying" a Christian to see what it will take to make their religious friend "give in" to their sexual advances. One woman commented:

So many times men do try women and women try men, because they feel that they're not any different. They feel like it's a game. It's a challenge. OK, she told me no this time, but how many times can I keep on doing what she wants done before I can get her?

A cultural norm of sexual behavior appears to be that African American men are not expected to resist pressure to have sex. One woman remarked, "Most men don't put up a fight. A few of them out there that do, but it's a lot of them that don't." Among women, however, the norm may be to expect mutual emotional involvement before having sex with someone new. Even when she was "out there in the world" having sex, one woman expected a minimal level of commitment in a relationship before she would go to bed with someone. She said:

It wouldn't have happened to me in one night, because I wouldn't allow that. 'Cause I would not have that. If you couldn't go along with me further than one night, then you got to keep on walking.

Perceived susceptibility

Lack of perceived susceptibility can be a more powerful predictor of risky behavior than "immorality" or lack of rational thought. One woman argued that she took

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risks in the past not "because we didn't have a conscience," but because "we just didn't think it would happen to us."

Among African American boys, perceptions about the susceptibility of others were revealed when they were asked to evaluate the "On the Pillow" video. One boy commented that the video scenario could actually occur locally: "It could happen in Gainesville," he said. Then another boy argued that even though it could happen in Gainesville, probably "it could happen to some bums." A third boy came to the defense of the first, contending that "it could happen to anyone." Then to justify his statement about "bums" being the ones at risk, the second boy said, "Oh no. It's the right and wrong." In other words, while some boys believed that any Gainesville resident may be at risk of HIV infection, one maintained that only the "bums" who do "wrong" are really susceptible.

Similarly, a boy in the pilot group implied that in Gainesville only prostitutes and social outcasts are likely to become infected. He remarked that AIDS is most common among "especially them desperate, ugly men – they always get AIDS. 'Cause you know them prostitutes probably give everybody AIDS. They open their legs, house to house to house."

One boy in the pilot group said he thought that black teens in Gainesville probably could get AIDS because "anybody can." However, several girls indicated that no one in their social networks is susceptible to HIV infection. When asked to think of someone who is not at risk of getting AIDS, one girl responded, "Everybody I know. At least, I hope." Then another added, "Everybody. 'Cause they ain't gonna be doin' all

that." A couple of girls disagreed. One argued that "anybody can get AIDS" and another commented that among African Americans in Gainesville, "they playing with AIDS."

When asked whether most African American teens are actually worried about AIDS, most girls indicated that many teens are concerned about others but not worried about themselves. One commented, "Yeah, they're concerned, but they don't pay much attention to it. It doesn't really hit close to home." Another added that "until it hits really close to home, then they'll open their eyes." One girl contended that African American teens "should be more worried" than they are. Several girls indicated that none of their friends seemed worried about getting AIDS.

The same held true for most girls when they examined their own beliefs. All the girls indicated that they are concerned about AIDS, but most did not feel they would ever become infected. One said she is concerned, but commented that "I feel like I know enough for now." Another agreed, adding that "I'm concerned but I'm not as concerned because I know I'm not going to have to suffer and die from AIDS."

Several other girls did express a sense of vulnerability to infection, with one remarking that "I don't want to die early," and another commenting that "I don't know as much about it, and I feel like I need to know more." Another emphatically remarked, "Yeah, I'm concerned. I don't want no disease."

Many women may believe they are immune to HIV infection because they are married or because they are already educated about the disease. But one woman addressed this belief by recommending that

> We get educated as much as possible so that we will be aware of not just it coming by sex or whatever it is, and how silly it may seem, but knowing that this is a possibility. Regardless of how wonderful I might think I am, I still need to be educated.

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Perceived threat

Most African Americans in Gainesville do not talk about AIDS, several women argued, because they believe the disease does not pose an immediate threat -- that very few people within their social networks have been infected with HIV. Several women made comments reflecting this lack of perceived threat among their peers:

> Half of us probably – if we not in a hospital or some kind of work like that – you don't know. You hear about it. You read about it. But you don't really know.

> It hasn't hit home. Nobody around them have it.

> It's like something that hasn't hit home close enough to them.

> I mean, that might be one person that you actually see, that you know has it. But what about all the ones that you're eating with, and going to lunch, and you're doing all these different things with, that may have it?

The prospect of AIDS continuing to spread may increase perceived threat. One woman commented that "you're wanting it to go away, but it's not going to go away. And AIDS is going to get worse."

The extent that church members perceive AIDS as a threat may be associated with whether their minister has personally counseled with a person living with AIDS. Jean Tapscott, an administrator with the national Agency for HIV/AIDS, commented that African American churches in Washington, DC, usually begin to address AIDS issues when their ministers "have experienced firsthand, in their church, the dying process." She added that "the church is moving. It's not where the general community is. The church tends to move more slowly."

When African Americans die of AIDS, and the cause of death is euphemistically called "a long illness" or simply attributed to cancer or pneumonia, it is difficult for local residents to ascertain how widespread HIV infection has become in their own

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community. The actual threat is veiled by euphemism and secrecy. As one woman commented:

> A lot of people don't own up to it, a lot of people who have AIDS. People don't know how widespread it is here in Gainesville because most people, they'll say, 'I'm in the hospital with cancer or pneumonia' or something like that. So people have no idea that they have AIDS. A lot of people are dying of it, but they're telling people it's something else that they have so they don't have to go through being rejected.

Perceived threat may be partly based on an individual's perceived threat about health risks other than AIDS. For example, one woman explained the roulette nature of risk-taking behavior by comparing AIDS risks with an example familiar to women who struggle to reduce the amount of fat in their diet:

> It's just like a person that has heart disease, and the conscience tells him not to eat certain things 'cause it could kill you. Then they say, 'Oh well, this one time.' And that be the one that take you out. Realizing that this thing exists enough that I don't care who you are, that one time that you take the chance at anything in life really, could be the one that take you out.

Perceived severity

Most focus group participants indicated that they knew AIDS is fatal. A woman remarked that "a lot of kids think you get it and you just die. Not so. You suffer. You hang in there a good while." This observation was reflected in the youth focus group discussions as well. All the teens knew that AIDS is fatal. For example, a boy in the pilot group warned that "if you get it, you gonna die from it. I'm not sayin' when, but you gonna die." However, none of the youths talked about the suffering of AIDS patients.

Comparing the fatal consequences of HIV infection with the inconveniences of unwanted pregnancy, another woman commented:

> AIDS is something that takes you out of this world. It takes your health away, you know, and you die from it. So it's even more fatal than someone goin' out there, messing up and getting a child. That's something that they have to deal

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with for 18 years or whatever, but with AIDS you not sure that you're going to be
here 18 years. And the majority of the time, they're not.

Although they may tend to feel invincible, teens lack the freedom to learn from

their mistakes in an age where one mistake could end their lives. A female pastor argued:

> They've got to know, OK, if for one minute you let your guard down and you do
> this, these are the consequences you may face – putting the picture out there that
> it's OK to make mistakes, but certain mistakes that you make now may take your
> life. I think that's the best message we can send.

Given that neither a cure nor vaccine for AIDS has been discovered, the publicity

about new AIDS treatments may lower the perceived severity of the disease among many

individuals. For example, an African American woman in Gainesville who has lived

with HIV for more than a decade has dramatically improved since she began taking "the

cocktail," a combination therapy that includes AZT and two other medications. After the

first month of taking the cocktail, her viral load dropped from 46,000 to less than 400,

while her CD4 count rose from 484 to 750. A CD4 count of 500 or less is a clinical

definition of full-blown AIDS, while a normal, uninfected individual would be expected

to have a CD4 count of 1,500 or higher. After doctors informed her of the promising

news, she was ecstatic. She recalled:

> I started screaming and they said, 'Now, wait a minute. You still have to take
> your medicine,' but I said, 'I don't care. That's some good news.' They said it
> could become undetectable, but they need to do more tests to see if a person can
> actually get off the cocktail. They don't know if it goes somewhere else in the
> body and hides. But I don't care. It's gotta be a miracle.

After receiving this news, she said "all the aggravation is gone now" and she said that

above all, "I just feel good about myself now." However, she is afraid that news about

success of "the cocktail" will hurt AIDS prevention efforts among youth:

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I almost think with the cocktail and all this stuff that's coming out now, they're not going to care. 'Cause they'll say, 'We'll go ahead and do it, 'cause we can go get the cocktail.'

Perceived benefits of practicing abstinence

When the boys were asked why some people wait until marriage to have sex, the reasons cited were disease prevention, financial support for a child, and the opportunity to advance their education:

Boy 1: If they're gonna have a baby someday, then they can afford the situation.

Boy 2: Babies – they are very, very expensive. You're the parents, so you're going to have to go to work and pay a lot of money for the day care and stuff like that. It gonna take a whole lot.

Boy 3: They might want to get their education.

Boy 2: If they have sex and mess around, they may not.

One woman said she advises her daughter to hold on to her virginity:

because once you give it away, it's not no renewal. No matter how long you wait before you go again, it's not no renewal 'cause it's old.' After they've gotten married, then she can lose that to him, but not before.

Perceived consequences of unprotected sex

In this study, AIDS prevention is the behavior change goal, and the postponement of sexual involvement is the recommended behavior in the application of the model. However, the perceived consequences of non-compliance with the recommended behavior are not limited to HIV infection. Many perceived consequences besides HIV infection could be more predictive of compliance and thus more useful in designing an effective AIDS prevention intervention targeting African American teens.

The emotional pain that can result from premarital sex was vividly described by a 16-year-old girl who said she had recently lost her virginity. Although the sex was

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consensual, the girl's mother had the man arrested and sent to jail on statutory rape charges. The girl reflected:

> If you're a virgin, you're gonna feel that you gave your virginity away to that man, and if he leaves you, you're gonna feel awkward. I'm feeling depressed, 'cause it just happened that one time. And you feel like it's all on you. And then, it's like you start to relive the incident over and over in your mind after it happened. Even if it's good, I mean, you still relive it afterwards.

Another focus group participant remarked that the girl's feelings were hurt "'cause that man take advantage of you." However, a woman in the focus group said she counseled this girl after the incident, and recalled:

> She said, 'Well, I just did it.' No reason at all. Out of the blue. And this girl is a very smart, intelligent young lady. She could have gotten AIDS.

When asked what they would do if a friend encouraged them to have sex with a girl, all the boys argued that having sex would be wrong but that even if they did have protected intercourse, they might still face the risk of HIV infection or unwanted pregnancy. One boy commented, "They say all you gotta do is use condoms. But something may go wrong." Another argued that "if you're not married, you cannot have sex. You can have sex, but one of the things is that if they not married, they could go have sex and get pregnant."

Other than the girl who discussed her statutory rape situation, the other non-virgin was a 13-year-old girl who was close friends with the first. The girls' focus group moderator commented, "I don't know if she was pressured, but I know the way she was talking, I don't think she wants to do it anyway."

In addition to naming AIDS and unwanted pregnancy as consequences of unprotected sex, boys in the pilot group also listed herpes, date rape, paternity suits, child support, sullied relationships, and jealousy as other consequences of premarital sex. One

boy commented that "it can kind of ruin a relationship. You've had that experience with that person, so you can't go back."

Uncertainty about pregnancy or disease transmission could be a perceived consequence of having sex. One boy admitted, "I'd feel worried afterwards." Several boys in the pilot group suggested a variety of scenarios illustrating the consequences of unprotected sex that apparently are commonplace situations that happen to others in their social networks:

> Boy 1: That person might be dating another person besides you. And the other person like finds out you've been doing it.

> Boy 2: Say you just datin', right, and you have a baby. But that's not the person you want to marry. Then you go out and marry somebody else. And then I'm gonna say that's my baby, and they're gonna say that's my wife.

> Boy 3: And one of them is gonna find out you're spending more time with the other.

> Boy 2: You'd have to pay child support, like pay for an apartment. The court can come give you a bill.

Sexual revenge attitude

The "On the Pillow" video portrayed Crystal, an HIV-positive African American woman, as seducing and deliberately infecting Terrence, a Christian African American man who was engaged to be married. This plot provoked much discussion about why a person might deliberately infect others with HIV. The idea that an HIV-positive woman should seek revenge by infecting other men as restitution for her plight may be a widespread attitude among African American women. A women's conversation that examined this meta-perception was prompted by the question, "What do African American women think about AIDS?":

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Woman 1: I've heard some tell me, 'If I get it, I get it, but I'm taking somebody with me.'

Woman 2: Bad attitude.

Woman 1: They have a negative attitude towards it. You know, I'm like, 'Excuse me? If I get it, me and that brother, we gonna have to throw down. That's my point of view.'

Several women also speculated about what a woman's motives might be for deliberately infecting others with HIV. One woman theorized that "some people just lose touch. They don't have no kind of guilt or remorse or nothing." Although some women felt that the revenge motive might be a popular norm among infected African American women, no one indicated that this attitude was acceptable. Another added that a woman in this situation might try to get revenge because a man hurt her, either emotionally or simply by giving her the virus:

There's not a good reason, but I feel that sometimes it's because if a woman finds that a man hurt her in that way, she feels she can get back at men by giving it back to them. In some ways, it was the hurt that drove her to that type of bitterness. They have it, and they know they're gonna die. They want to take as many with them. It's reality. And a lot of times, because of them feeling deceived, they feel that all men are bad. 'See, I can get him to do it because he's not faithful, and he's gonna jump in the bed and do it anyway. So let me just go ahead on and give it to him.'

The revenge plot was the only aspect of the video that the boys said they didn't like. This may be an indication that sexual revenge is both hated and feared among African American males. For example, one boy said he disliked "that idea, if I'm going down, I'm gonna take everyone with me." When asked if they thought the girls in the focus group next door would react differently to the video than they did, several boys instead implied that the girls would behave like Crystal, the HIV-positive woman in the video:

Boy 1: They'll leave you, you feel great, and they write you a note.

Boy 2: So you'll feel great, and they'll write you a note. Bye-bye. It's like she got what she wanted.

Motives

Teens' motives for having sex often may be irrational, based on the need for physical gratification. For example, one boy explained that they do it "because they hot." Another boy, a participant in the pilot group, commented that "when you're in your teens, when those urges are strongest, maybe you can't afford to say no."

When people are aware of everyday health risks other than HIV infection risks, they may be more likely to attend to AIDS prevention messages as well. For example, one woman commented:

Something is going to happen, one way or the other. If it's not AIDS, it could be something else. We're always eating things with fat, and people are dying, having strokes and heart attacks, high blood pressure. People are trying to teach us.

For many Christians, a primary motive to abstain from risky behavior is to avoid the eternal damnation believed to be the final punishment for sin. One woman warned that "God says if you're an adulterer, you're going to Hell because you're sinning."

One woman with a history of "partying" said she identified with Terrence, the main character in the "On the Pillow" video. She argued that Terrence's motive to "get it out of his system," rather than his alcohol consumption, was the key influence upon his decision to have premarital sex with a stranger:

What happened to me – it wasn't the alcohol as much as it was getting caught up into something he know he had a problem with. He thought he could get it out of his system, for this one last time, and when he got married he would be faithful.

Figure 20 below depicts the overarching framework for this study, highlighting the normative processes, as identified by research participants, that could influence whether individuals engage in AIDS dialogue or comply with AIDS prevention advice.
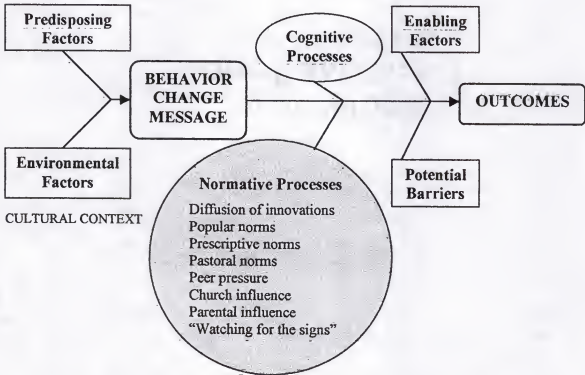
FIGURE 20: Normative Processes, Identified by Research Participants, that Influence Individual AIDS Preventive Behavior

Diffusion of innovations

At the time this study was conducted, no official AIDS ministry existed within any African American church in Gainesville. Thus, it is assumed that starting an AIDS ministry within African American churches would involve radical change in religious and institutional norms.

The African American churches may have failed to initiate AIDS discussion because the perceived need simply may not exist. Very few church members have

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publicly admitted that they or their family members are infected with the virus. One woman said:

> I think like right now, nothing's really gonna go on. But in the future, you'll see more demand, because there's gonna be more of it in their churches. Then they'll wanna do something about it.

The African American AIDS Task Force likely could serve as a change agent to initiate programs promoting AIDS-related dialogue because this organization has the resources and credibility to initiate change. The innovators could be visible leaders within the churches, such as deaconesses and Sunday school teachers, who could serve as liaisons between the change agent and the church members.

Several women in the focus groups volunteered strategies for initiating AIDS-related ministry among African American churches. One woman suggested that the first step would be to "get to someone who really cares about their people." According to diffusion theory, this person or small group of individuals could be considered innovators or early adopters, depending on whether they continue to "spread the word." The woman went on to explain:

> It's just like anything else. You may get to certain places, and you have to deal with the people who actually want to hear about it. So once you find the area, maybe it's in one church out of 10. Usually out of 50 people, you'll get one person that come up, and they're really interested in what you talked to them about. And they'll go, 'I want to get more involved in this.' That might be their ministry, something that they really want to deal with. With the others, it might not hit home right now, but later it may. And that opportunity will arise that they will be able to actually use it, even if they don't feel like they need it right now.

According to diffusion theory, these innovators would be expected to begin engaging in conversations that promote AIDS awareness and dialogue among friends and family within their social networks. As the innovators "spread the word" to various members of a particular church, more members would accept and adopt the "innovation"

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of AIDS dialogue in that context. Eventually, a consensus would be reached among most members – a consensus that either asserts that talking about AIDS is beneficial or that this kind of dialogue is unnecessary or potentially harmful. At the same time, however, the AIDS dialogue would continue to spread through a multitude of other social networks outside that particular church, depending the types of social ties that each person has within the larger community.

African American ministers could serve as innovators by launching AIDS prevention initiatives within their churches that could spread to individuals throughout the community. A male pastor argued that AIDS prevention efforts should begin at the grassroots level and then branch out through various social networks:

> We should get some form of communication out to every home. It could be literature, PSAs, some type of community workshop, or forums that can be done for a number of social organizations like fraternities, sororities, and schools.

One woman witnessed the diffusion phenomenon within her own church, which recently had begun initiating outreach and evangelism to the underprivileged throughout the black community. She explained:

> In my church, they go out and feed the people and minister to them. But you don't have that many. You may have one church out of 10 that does that. But if you work with that one church and they get educated, then they can help educate other people. And through that, it keeps traveling and it may go to that church that maybe you couldn't reach. So I think by meeting with groups outside of the church as well as inside of the church, the ones that you can't come in and actually deal with, then you just try to deal with other groups.

Network diffusion of AIDS information could be a far more effective tool in changing community norms, as compared with mass mediated campaigns that target individuals with a behavior change message. One woman commented:

> Word of mouth really does travel fast. A pamphlet could be laying here for years, and somebody could walk by and won't pick it up. But you put it in somebody,

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and if that person really is interested enough, like she was saying, then they gonna tell somebody else, and somebody else gonna tell somebody else, and they'll be saying, 'They really got an AIDS thing going.' And then this person gonna get interested. It really goes by word of mouth, more so than any other thing.

The "word of mouth" strategy not only promotes dialogue within organizations and institutions, but also appears to promote intensive dialogue between individuals who are actively involved in personal community outreach and others who would be considered weak or non-existent ties within that person's social network. For example, one woman explained:

I've been wondering about how I can actually let people know that I'm there for them. So by word of mouth, a lot of times people do end up coming to me, and I talk to them or whatever.

Popular norms

Popular norms involve perceptions of which behaviors are typically or customarily performed. Among African American teens, popular norms about sexuality include perceptions about virginity, aggression, and promiscuity. For example, a boy in the pilot group said that some of his friends "brag" about having sex. He remarked that "some people say it, but you know they lying. You know they lying."

One woman speculated that teens probably would react differently to the "On the Pillow" video than the women did:

They're like, 'I wouldn't do nothing like that. I wouldn't have run out that way. You know. I would have at least got checked out first before I did something like that.' But with the younger ones, they'd be like, 'OK. Man, she's fine. She's ready to give it up. I'm going for it.'

Another woman added, "Most of the younger ones would think that. 'If something fine and pretty like that come to me, yeah, I would do that, too.'"

In guessing about the sexual behavior norms among the girls in the focus group, the moderator remarked that she "didn't actually see any hoochies there. The ones that I feel were virgins were wearing pants and baggy-looking shirts." She further speculated that all but two of the girls were virgins. She commented:

> I could probably point out two of them that are not virgins. And that was about it, out of all those girls. Two of them basically said they weren't virgins. The rest of those girls, they have no experience whatsoever.

One woman suggested that adult women are less likely to become infected through sex than teenagers: "But us, on the other hand, we're more alert about things, and we care about our body." Despite this awareness, many focus group and interview participants considered infidelity among African Americans to be widespread in their community. One woman commented that "we have to know that it's a lot of that going on. It's a lot of people just going out there." Infidelity also may be commonplace within the social environment of many African American teens. When asked how the characters in the video were like people she knows in her own life, one girl commented that "the man is like people I know, 'cause he cheated on his wife."

Although all the boys said their friends are unlike the characters in the video, several said that the people they know, other than their friends, really "ain't different." A couple of boys said they are "smarter" than the characters in the video, and conversely, one remarked that "those people retarded." However, one boy wondered aloud why being smarter or less smart really matters when "nobody can even see you do it."

The youth moderators' participant observations of the teen focus groups indicated that girls may be far more focused, attentive, and interested in discussions about AIDS than boys of the same age. While moderators conducted the youth focus groups, adults

were not allowed to enter the rooms. This strategy was used to encourage greater spontaneity and openness in the discussions among the youth. However, it also prevented the investigator from observing the participants during the sessions. After the sessions ended, the youth moderators offered comments about behaviors and themes that they noticed during the sessions.

The fact that the girls knew each other, the girls' moderator argued, helped facilitate discussion because it probably made many girls feel more comfortable sharing personal feelings. She speculated that in a group where girls do not know each other,

> I think they won't speak up. If I didn't know them, I'd just sit there. I'm just saying when you have a new group of people in a new class, and you don't know anybody and nobody knows your face, I don't think anybody would talk. I think it's best that they know each other, and they also feel closer to the person.

Girls also tend to volunteer only the opinions perceived to "fit" with the opinions of their peers, especially when talking about sexuality and other personal issues. The girls' focus group moderator noticed a social desirability effect among the girls when they were discussing personal sexual issues. She observed that several girls

> kept changing their minds when they were talking about whether they want to have sex. I feel like most of them were just listening to people.

Physical aggression and yelling appear to be normative behaviors among pre-teen boys in situations where they are supposed to pay attention to an adult or other non-peer. During all focus group sessions, most boys tended to be disruptive, inattentive, and loud. During the first focus group session, a hyperactive 11-year-old boy began antagonizing a much taller 13-year-old boy by calling the older boy's father derogatory names. The altercation ended with the older boy shoving the younger one into a door, and an ensuing din of yelling erupted among the other boys. Several weeks later, it was determined that

the older boy's father was in prison, and his stepfather had died of AIDS three years earlier. During the second focus group session, the same younger boy repeatedly yanked the protocol and tape recorder out of the male moderator's hand. A youth group leader said this boy frequently misbehaved because he was not given his Ritalin as prescribed.

Prescriptive norms

Prescriptive norms involve perceptions of which behaviors are societally sanctioned or customarily approved. A prescriptive norm among African Americans may be one of taking personal responsibility to halt the spread of AIDS. For example, one woman commented that Terrence, a character portrayed in the "On the Pillow" video, was mature because he "didn't do like she did and pass it on."

Monogamy may be another prescriptive norm, even if individuals are not expected to maintain a long-term monogamous relationship. For example, one woman argued that a couple should not become physically intimate if either of them is already involved with another person, and each person should ask the other about outside involvements or commitments if the information is not volunteered. The woman commented that the video character Crystal "didn't even ask if Terrence was dating anybody else. And he didn't say anything. But I would go further. I would ask."

Casual sex with strangers was considered irresponsible by most focus group participants, regardless of age or gender. One woman commented on Terrence's behavior in the video, saying:

> Regardless of if he was drinking or not, he never seen that person before and he never have should went took her back to his place from the jump, you know.

Many prescriptive norms about sexuality may be created by adults for adolescents. One woman argued that it is easy for married adults to sit on the sidelines

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and criticize the young people who struggle with sexual dilemmas. Referring to the tragedy portrayed in the video, she commented that "we can sit and say what they should have done and how much they should have done it."

Getting married appeared to be a prescriptive norm among the African American teens, even if most adults in their lives are not married. When asked why people get married, one girl simply said, "because of babies." However, another believed the primary reason should be emotional involvement.

She explained:

> People get married because they feel that their relationship, if they be going for a while, they love each other so much they want to go to a higher level.

Various participants within every focus group argued that couples should get an AIDS test before taking their vows. One boy in the pilot group said he plans to do this when he meets the "right one":

> Right before I get engaged, I'm gonna be like, 'Come on.' She might think I'm sick, but what if the doctor tells me she's got AIDS?

Pastoral norms

The prescriptive norms that apply to ministers, as perceived by teens, may be important to ascertain before designing an AIDS ministry targeting youths with prevention initiatives. These perceptions may indicate the extent that ministers can serve as credible, respected role models, teachers, and counselors in promoting AIDS-related dialogue.

Apparently, some teens expected their minister to hold certain attitudes and use particular counseling approaches that they consider to be appropriate and conducive to open, helpful dialogue. A good minister is assumed to think and communicate on the

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same level as teens, except that he also is expected to dole out moral or spiritual advice. For example, when asked how her minister might react to the "On the Pillow" video, one girl said she thought he "would probably agree with us." But another girl added that "they'd try to convince us not to do it and everything."

Several prescriptive norms for pastors emerged through focus group discussions about the portrayal of a minister in the video. One girl said she did not like the minister in the video "'cause he didn't seem like a pastor to me." Another girl added, "Yeah, like the part where he cursed." Her comment refers to the end of the film, when the pastor shouts, "What the hell is wrong with this world?" One girl said she respected the young man going to his pastor but did not like the pastor's forceful demeanor, such as "where he made him open the note and said he should have come out and told him in the first place." Another girl explained:

> It seemed like he didn't show enough emotion, and like he was yelling at the guy trying to get him to talk about it. He was forceful. He didn't take his time in trying. He was too mean to him. He got on my nerves.

Several girls said this attitude was not appropriate for a pastor, particularly in comparison with their own pastors. One added that "he was putting in more of his own emotion instead of trying to be a pastor," while another said that she "could see it if it was his child or something, but this was a person that was coming to him."

Peer pressure

When a teen tries to gain the respect of friends or save face, these behaviors can be evidence of peer pressure, and they may be motives for initiating sexual involvement or pretending to be sexually experienced.

Several boys in the focus groups said that teens have sex to avoid the embarrassment of being labeled a virgin. "They want to fit in with the crowd," one boy commented, and another added that "they don't want to be like a virgin." A female pastor said many African American boys and men are promiscuous because they want to prove their masculinity:

> A lot of them are like, 'Well OK, I'll sleep with this one. Hey, that's what makes me a man.'

Despite this peer pressure, one *fotonovela* evaluator said a lot of the sex talk among boys is just bluffing and bragging. She remarked that "those guys sit around talking about sex and stuff, and a lot of them tell lies because I bet you about half of them are virgins." Another evaluator added that "a lot of my friends tell me a lot of boys talk a whole lot about it. I mean, they don't even have girlfriends or anything."

In some cases, peer pressure may have little to do with sexual behavior among teens. For example, one boy said that "the reason virgin children have sex is not because of the crowd. It's because they have a girlfriend." A boy in the pilot group said his friends' comments do not play a role in whether he pursues a girl: "If I see a fine girl, I'm going to try to walk up to her myself and her lady friends."

Girls may be more likely to give in to sexual pressure from a boy if he plays football or basketball, one woman speculated. When a boy has this kind of social status, she said, "all the teenage girls wouldn't mind having him as a boyfriend." The thrill of being "singled out" by an attractive or seductive person in the presence of peers, may create an even riskier situation. Recalling how this scenario was depicted in the "On the Pillow" video, one woman commented:

So, let's think about the picture for a minute. Just think, she walked into the bar. She looked all around. All the other guys are there. But she chose him. All he had to do is say no. It was directed to him.

Terrence was in the company of his beer-drinking friends when he decided to give in to a stranger's seduction. After watching this video, one woman theorized that if "a child's in a group of guys, girls, they'll do the same thing he did."

Several girls cited peer pressure as the main reason that teens drink, including attempts "to be cool" or the desire "to prove to their group that they cool." Other girls argued that some teens are not pressured to drink, but just do it because "they don't have anything else to do" or just "'cause they want to."

Some teens believe that standing up to "the crowd" is not impossible, even if it is difficult. If her friends pressured her to become sexually involved with her boyfriend, one girl said she would not agree with their advice and added that "they are your friends, but they just don't understand you." Another girl commented that she would tell them her relationship with her boyfriend "is between me and him."

One woman suggested that a person's gender or age doesn't have much influence on how they respond to peer pressure:

If it would have been a teenager or it would have been a man, because of who they was with, or either a woman or a girl -- they would probably react the same. I don't think there would be too much difference, because of peer pressure.

Teens may often become sexually active when virginity is considered a stigma. A female pastor observed that "now virginity is something to be picked at. So most kids worry about what the other kids are thinking. They'll try to show them every time that, 'Oh, I'll do this.'" An incident involving several church-going African American boys convinced her that peer pressure motivated them to engage in risky behavior:

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I actually overheard three kids talking that they went to the pool and girls that they didn't even date – they had sex with them right there in the pool. And these were kids that are in the church, in somebody's church. I was like, even though we're teaching it, we've got to find another way to actually get it out to them.

The desire to be seen as an adult may motivate many teens to succumb to peer pressure. A female pastor said she tries to appeal to this motive in her abstinence advice to teens:

They all want to be grown, but what makes them grown a lot faster is being able to not let someone entice you into doing something you shouldn't.

The quest for higher social status may be another common form of peer pressure among African American teens. A female pastor said she has heard boys frequently complain that

'I've got to have 500 tennis shoes because they're going to pick at me.' We run across that all the time -- 'If I don't get another pair of tennis shoes, I don't want to go to school.'

One mother said she sees evidence of the pressure to conform in the way her 13-year-old son often dresses for school. The woman said she tells him that "'it's no comfort in wearing your pants below your buttock line, acting like you're so cool. Where's that going to get you?'"

Church influence

Socialization in the church may help reinforce prevention advice among youth. A *fotonovela* evaluator recalled hearing a preacher's sermon about sexuality that "was like, it's summertime, and you guys are feeling hot, but it's not the temperature." One participant in the second women's focus group, a Sunday school teacher and summer youth program assistant, said she discussed sexual negotiation with her class during the *fotonovela* project. She recalled that the class talked about

being alone with a guy, and he's trying to get you to do something that you're not ready for and you feel uncomfortable with and stuff. You tell them you say, 'No, I don't wanna have sex,' and he still trying to force you into that situation. But he's gonna do like, 'I love you' and 'You fine.' I told them that you simply don't know what's wrong with him, and it could be the AIDS virus. And when I was reading it to them, we just had a good Sunday.

During this Sunday School lesson, she also asked the teens to talk about how well they communicate with their parents. She asked them a series of questions, such as:

Are you able to sit down and be open with your parents and talk about sex and different things? Can you talk to them? I wonder if I'm doing it, will I let my momma and daddy know? Maybe I'm doing it sometimes just to do it?

The key to living a good life, one girl said, is to obey God. However, religiosity apparently can lead to inner conflict among many church-going African American girls. One girl reflected that even though she goes to church and tries to be a good Christian, "it's really hard to be a virgin." Another girl commented that she is postponing sexual involvement "because the Bible says it's a sin, and if you're a true Christian you're not going to do it. You're going to do it, but you're going to try not to."

When asked whether it is OK for a Christian to have sex before marriage, the girls unanimously said no. The reasons included avoiding hell, following the Bible, and avoiding a mistake. One girl speculated that non-religious people probably do not abstain from sex because they do not receive this kind of advice: "If you're not in the church, you really don't care about it."

All the boys seemed well aware that the church condemns premarital sex. One strongly argued that "it's a sin to have sex before you're married. It really is. You can have sex after you get married." However, none of the boys really knew why this is taught. When asked this question, one boy responded, "I don't know. 'Cause it's in the

Bible, I guess." Another boy challenged the teaching, using an example from the Bible itself: "Adam and Eve had sex. They had Cain and Abel."

Talking about sex in church, however, may not always discourage teens from engaging in risky behavior. In the "On the Pillow" video, Terrence's fiancee, Alisha, was presumed to be infected because Terrence had a one-night stand with HIV-positive Crystal, a stranger at a bar, and then slept with Alisha before getting an AIDS test. One woman observed that the Christian upbringing of Terrence and Alisha did not ultimately prevent their exposure to the virus:

> She may not have been sleeping with anyone but him. And it seems like to me both of them had the right start. They were both in church. So it wasn't like they didn't know anything about what they shouldn't do, you know, about sex outside of marriage. And still yet, she had sex with him before marriage.

A key informant from the Task Force argued that African Americans who seldom or never attend church and church members who have "backslidden" are most at risk of contracting HIV. She argued that outreach efforts should target these people first:

> Some churches just don't want to discuss AIDS because then they might have to face up to the fact that somebody in their congregation might not be living the way God told them to -- backsliding, tip-toeing around, whatever. That is a problem. The people who aren't living right aren't in church. We should reach out to get them.

A male minister argued that even people with high social standing or a good reputation need to hear about AIDS in church. He explained:

> I can't assume that because you are so-and-so's daughter or your mother's been in church for years or your father's been a faithful worker that I don't have to discuss this with you. We need to talk about everything that's out there. We need to talk about possibilities that it can knock on your door.

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Church attendance and involvement in organized religious activities can help a Christian maintain a healthy lifestyle. When ministers present advice based on Biblical interpretation, it can reinforce lasting behavior change. One woman commented:

> When we go to church, the pastor's always preaching about the things you shouldn't do, the things God will not allow you to do. Eventually, if you hear it long enough, some of that's going to soak in. If you utter that Word daily, I mean, every week and Wednesday night prayer, it's eventually gonna sink in, if you wanna live like this.

Parental influence

Several boys indicated that abstinence advice has primarily come from their parents. When the boys in the focus groups were asked to indicate whom they would prefer to talk to if they had a problem or question about sex, several said they were comfortable talking to their mothers or to both parents. However, most said they would prefer to talk to their fathers, and they perceive their fathers as more down-to-earth and knowledgeable. One boy said his father is more open and understanding. He commented, "I'd talk to my dad. He talks to me about everything. He always talks. He understands me."

Another boy agreed, saying he would rather talk to his father even though the man might lack the sexual experience that his friends have:

> I talk to the ones that's more experienced about it. Man, I be like – see I talk to my dad too, you understand. But my dad is old, and he ain't havin' none of that no more, you know what I'm sayin'?

Some boys preferred to talk to siblings or friends rather than their parents, when it comes to talking about sex. One boy recalled having a discussion about sex with his brother but added, "I can't really tell you how it was started." Another boy said that if he

ever had concerns about sex or relationships, he would probably just talk to his sex partner.

When asked to tell the least favorite person to talk to about sex, one boy named his mother. Another boy said he hates talking with his mom about sex, but added that "now my daddy, he knows about sex." Another boy disagreed, saying that he does "talk to my momma about sex."

Most boys in the boys pilot group also said they would probably go to their fathers or older brothers before they would talk with their mothers about sex. One commented, "I like, talk to her, but she fuss with us. But my father I'd ask a problem." A couple of boys, however, said they would prefer talking with their mother. One said he would probably call an AIDS hotline instead of talking to a parent.

The women were asked what they would do if one of their children admitted to being sexually active. Most said they would try to begin talking to their children before they became sexually active. One woman said:

> That's where that open line of communication comes in. A lot of kids who can talk to their parents are extroverts. I could do that. I was very open with my mom and my grandmother. I was ready to be sexually active. I was like, 'Hey, Mom.' 'What's up, girl? We going to the clinic.'

Another woman argued that setting up firm rules for her children helps them develop long-term decision making skills. She explained:

> There are certain rules, certain regulations, certain disciplines that you must maintain in order to be a responsible person. I can speak for the rules in my house. If you honor that, then I'm sure when you're on your own anywhere – if I allow you to go spend a week at camp for the summer – you will be responsible in your thought patterns, what is right for you and what is not.

In a study of AIDS dialogue between parents and their middle-school aged children, Whalen (1996) found that parents tend to be more mutual with daughters and

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more directive toward sons. In the present study, one boy recalled a piece of directive parental advice: "They go like, 'I don't want you doing this 'til you married.'" Another boy related that his parents do not forbid him from having sex but insist that he does not do it under their roof: "My parents say if you're gonna get it, you want it, then you take it outside and leave it out there."

Another focus group participant, a mother of two, said she tries to help her children cope with peer pressure by using a directive approach. The woman said she already has told both her children, 'You ain't ready for something like that. I'm your girlfriend. I'm your boyfriend. Until I say you's ready.'" If one of her children insisted that he or she was ready to become sexually active, the mother said she would probably ask, "'Are you sure it's not pressure? If it's pressure, then you can always say no to pressure.'

An example of a parent using a mutual approach to sexuality dialogue was the case of one mother who said she fostered open communication with her 10-year-old daughter by offering to play the role of a friend. She said she tried to put aside her parental role for a while to help her daughter open up:

> She has like something she wants, and she say, 'Mom, can we play friends?' And I'm like, 'Sure.' You know, 'friends' is I'm her friend, but I'm not her mom. She's discussing things that's bothering her. And as a friend, I'm giving her advice. You know, what I would do if it was me. We've been doing this ever since she's about 4 or 5 years old. We'd get us a little tea party, and sandwiches and stuff. It gives me the chance to take my mind off what's pressuring me and get down and think as a child and to play a child's role with her. And she feels more secure with me playing a friend than coming straight out and talking to Mom, even though she's talking to Mom.

"Watching for the signs"

During the second women's focus group, a piece of advice repeated many times was the parental warning to "watch for the signs." Throughout the session, several women related their own parenting stories and reiterated this advice. The "signs" are bits of subtle evidence suggesting that a teen may be engaging in risky behavior. In describing her own parenting challenges, one woman explained:

> We've got to pay close attention to our children 'cause a lot of them will get in situations. We can't put it all off on the children, we got to put some off on the parents, 'cause I'm a parent myself. I was a working parent and when he was in school, he was in the hands of somebody else. But when I was home, I was with him. But still, I made mistakes 'cause I was a single parent. I couldn't keep an eye on him 24 hours, but I tried to. I had to get rest sometime. Still, I tried to raise them as good children.

Other African American parents should be taught how to watch for the signs as well, one woman contended. Many parents do not look for signs because they believe a religious home life protects their children from trouble. But given the influences of peers, this woman warned, parents cannot afford to

> feel like, 'I've taught my daughter, so I know she's not going to do it.' You can't go by that. It only takes one guy to switch it. A lot of people have taught their kids all their life not to go and have sex.

Another woman, a prominent leader in the church, admitted that she had overlooked signs of her son's drinking problem:

> My oldest son has always been real private. I have found out he was drinking and stuff while he was going to school. We had no idea. This was our good child. That was that one we told no, and he didn't do it. But he's not the one who does it in front of your face.

Being a good listener is the best way to watch for the signs, one woman argued. She explained that "they're gonna give you the key. If you listen, they'll give it to you. We're responsible for when those signs come, for us to stop right then, and do whatever it

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takes to try to work it out." Another woman asked for clarification of the group's consensus: "Everybody sayin' watch for the signs. But what are the signs?" To provide an example, a woman related a story about how her instincts were right on target when her daughter became pregnant:

> My daughter was getting big in her bust and her hips, and I'm like, 'OK, you sure you're not pregnant?' 'No, Momma.' I'm just talking to her and talking to her. She got sick, and I gave her Advil 'cause I thought she was having bad cramps. And then when she was still sick, I took her to the hospital and they told me she was getting ready to deliver. They told me her son was not too big, and that she was going to miscarry because she was too small. She had a full-term baby. It weighed five pounds, eight ounces. She had no prenatal care or anything. I'm here to tell y'all, when you say watch for the signs, let me tell you – really watch for the signs.

Another woman related an example showing how "good" teens from prominent families sneak behind their parents' backs to engage in risky and forbidden behavior:

> A pastor friend of mine said they had a garage, and she wanted to put a bed out there. They was like letting some people come and stay with them. She and her daughter went out there to clean it up together. And she kept seeing the signs. Every time she was talking to her, she says, 'No. I'm not doing anything' and all that. Next thing she knew, she put a bed out there, not thinking her good 16-year-old daughter that she's got in the church, raising her just right, would do anything. And all of a sudden one night, the Lord said, 'Be quiet and listen.' And next thing she know, she heard something in the garage. And He said, 'Don't go running out there. Just wait.' She waited, and after a while she heard a man's voice. And next thing she knew, she seen her daughter sneaking out of there, trying to go to the bed outside to that room where the guy was. And then when she went out there, come to find out she had been bringing friends there all the time, guys and everything. And she threatened the other kids in the house, but they said they're not telling anybody.

Enabling Factors

Figure 21 on the following page depicts the overarching framework for this study, highlighting enabling factors, as identified by research participants, that could help or

encourage individuals to engage in AIDS dialogue or to comply with AIDS prevention advice.
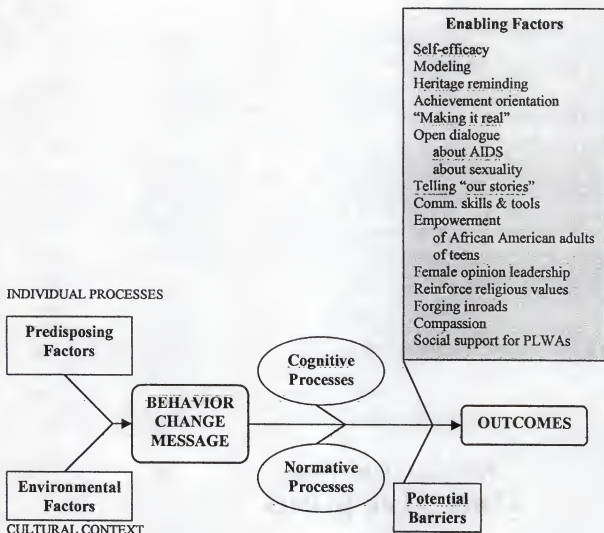
Enabling Factors

Self-efficacy
Modeling
Heritage reminding
Achievement orientation
"Making it real"
Open dialogue
    about AIDS
    about sexuality
Telling "our stories"
Comm. skills & tools
Empowerment
    of African American adults
    of teens
Female opinion leadership
Reinforce religious values
Forging inroads
Compassion
Social support for PLWAs

INDIVIDUAL PROCESSES

Predisposing Factors

Environmental Factors

CULTURAL CONTEXT

BEHAVIOR CHANGE MESSAGE

Cognitive Processes

Normative Processes

Potential Barriers

OUTCOMES

FIGURE 21: Enabling Factors that Facilitate Individual Compliance with AIDS Prevention Advice

Self-efficacy

Locus of control is a key element of self-efficacy, because individuals must perceive that they can control their own behavior and the factors that influence behavioral outcomes before they can gain self-efficacy. One woman argued that adults need to take

control of their own lives, to convince youth that they too are capable of overcoming peer pressure to follow through with prevention advice. She remarked:

> I guess to get kids, you have to take charge of yourself as an individual. Don't worry about what the pastor's doing. Don't worry about what your friends are doing. You need to know that even though it happened to them, it could happen to you.

The perception that learning about AIDS is an effective weapon against infection is a form of response efficacy. One girl's question highlighted the belief that knowledge and awareness about AIDS will slow the spread of the disease. She asked the other girls, "When we have our children, is it gonna be worse for them, or is it gonna be better?" Another girl answered, "I think it'll be better, 'cause we know more than they did."

Realism of the *fotonovela*

Apparently, the booklet successfully depicted typical, everyday situations among African American teens. For example, one girl remarked, "That's how most people get together. They go to a friend's house, watch a movie and chill, and stuff like that." Another girl added that "it what goes on every day. Like the story." One girl said that some of these situations have actually happened to people she knows.

One woman said the title of the *fotonovela*, "Afternoon Delight," was "very dynamic" and describes a common scenario among many African American teens. She added:

> For kids, that's exactly what it is. Because the national Gallup Poll's already told us that's the time that kids have the most time to themselves – the TV, and Mom and Dad is not home.

Although several women argued that the *fotonovela* was not hard-hitting, one noted that the story instead portrayed typical, familiar situations among African American teens:

You know, it was mild, but this is such a typical scenario. Somebody goes to school, and you go home in the afternoon just like she was saying.

Another woman agreed that a *fotonovela* should "use their own scenarios, the things they go through on a daily basis."

All the girls agreed that the booklet looked and sounded realistic. One girl volunteered that "they put our everyday language in there." However, one *fotonovela* evaluator said she did not like the use of improper grammar and slang in the booklet. She remarked, "I don't like the way they talk. I just really don't care for that kind of English."

One girl commented that "the stuff that she had wrote on the way that they lookin' and stuff like that, the way they actin', they look real."

The boys also agreed that the story was realistic, but none said that any of the situations had happened to them in the past.

Perhaps some boys thought the story was completely true, rather than a dramatization. When asked if his friends thought the story was real, one boy responded, "I know everybody know it's real. It ain't no movie." Similarly, when asked what type of story was used in the booklet, one boy said, "A true story," and another boy remarked that "it could really happen."

A concern in developing the *fotonovela* was the possibility that the story's actors might be seen as people living with AIDS. Even if some teens perceive that the *fotonovela* actors have AIDS, however, the booklet presenter can turn the misunderstanding into an informed and focused discussion about AIDS risks. For example, one woman recalled a conversation she had with several boys in her neighborhood, after they read the booklet:

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Boy: These kids got AIDS?

Woman: No, they don't have it. They just doin' a role.

Boy: They don't even look like they have it.

Woman: See, that's the problem. You don't look like you got it, but you have it.
        You could look all healthy, fine, and sexy.

Boy: Yeah, that's true.

Apparently, the boys thought Kevin's sexually aggressive approach in the story

was typical. The title of the adult video pictured in the *fotonovela* may have illustrated

this social norm. One boy remarked that "he ran and got himself 'mo booty.' And that's

what happens all the time."

One boy argued that a booklet should depict the realities of street life because that

is where many people become infected. He commented:

> You just need to go to like a store, and show ho's roughing around, 'cause
> sometimes you'll have AIDS. 'Cause they like walking around.

Apparently, a character in the *fotonovela* may have been perceived as fake. When

asked what his friends said about the story characters, one boy said, "One guy was like,

lying." A situation that might not be realistic, for one girl, was the *fotonovela*'s scene in

which Tatiana became uncomfortable with the romantic situation at her friend's house

and found a way to escape her predicament. The girl who played Tatiana's character

remarked, "I wouldn't get out of it by walking the dog." A young girl with HIV was

portrayed in the *fotonovela* as presenting her personal story in church. One girl in the

focus group thought this scenario was not realistic:

> I don't think people would tell the truth if they had AIDS, in front of other people.
> And some people don't feel like they should tell that, if this person really did have
> it.

Fear appeals in the *fotonovela*

Given that previous research has shown that high fear appeals are less effective than milder fear appeals in leading to attitudinal or behavioral change in individuals, the *fotonovela* story used low fear appeals. The information conveyed the severity and seriousness of AIDS, but the story was not the typical "scary" tale of a young person dying as a result of a mistake. However, many focus group participants said the tone of the story should have been more tragic and less "everyday" and typical.

One woman argued that the *fotonovela* should have graphically depicted the tragic consequences of AIDS in order to make a persuasive impact on teens. She remarked:

> I think it's too mild. I think it really should have had a little more punch to it. It should show that AIDS is going to kill. I'm trying to see the effect, what it's going to do to people. I want them to see how they have sores on them, sore throats. Give them something to really picture in their mind.

The tone of the booklet was appropriate for its purpose, one woman argued:

> I think in its mildness, it leaves room for you to talk. I mean, this isn't supposed to do everything. This is just a tool for you to open a door.

The message that teens die of AIDS was found in both the *fotonovela* story and raps, and the facts listed on the back provided AIDS death statistics. However, none of the teens perceived that fear appeals were used in the booklet. One boy remarked that "nothing was scary. Just trying to tell you what to do and what not to do." Another boy believed that teens will not change their behavior unless the fotonovela is "scary." He explained:

> If it was scary, and it was about AIDS, then most people would stop what they doing and read it. And when they read it, instead of going out and then doing what they want to, then they try to stay out of it, instead of going out and catch AIDS at an early age.

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In characterizing the mood of the *fotonovela*, one boy remarked that "it's kind of sad, but not a lot." A few boys complained that the everyday tone of the booklet was not appropriate for a subject as serious as AIDS. One boy remarked, "We just going outside playin'. We can catch the basketball and all that. But we talking about AIDS."

Teens will probably put the booklet down, another woman argued, "if you don't keep bringing them back to this, 'My God. Man, I didn't know these things happen.'" A *fotonovela* evaluator agreed, arguing that showing the consequences of risky behavior may elicit enough fear to discourage teens from engaging in risky behavior. She remarked, "I mean, you scare them half to death with all this AIDS and STD stuff. They ain't gonna want to do it." However, one woman disagreed with the fear appeals strategy, arguing that some teens will refuse to read any AIDS prevention material even if it is designed to scare them.

The only reason his friends might become involved in learning from the booklet, one boy argued, would be if they were already afraid of contracting the virus. Otherwise, he contended, they would ignore the prevention advice because their behavior would be driven by lust. He explained:

> Like some people in school now scared of AIDS, so if they don't want to catch it, then they need that book. But some people just don't care what they do. They walk around, in sexual arousal, and people don't know what they doing, and go around harassing people. Then when people do it, and they catch AIDS. And they all wonder why people did it.

Using fear appeals among African American boys might backfire because a fear response might threaten their self-perceived image of toughness and lead them to challenge each other to prove their fearlessness by engaging in the dangerous activity.

Modeling

Social modeling has been used in AIDS prevention campaigns to encourage individuals to imitate a respected person. This form of modeling also could be used in interpersonal contexts as well, where opinion leaders can set a positive example for teens. For example, religious leaders could serve as role models for young African Americans, but danger could arise if the role model engaged in behavior that is seen as hypocritical. One woman commented, "Looking at people that you think are up here that won't fall – mistake number one."

The desire to imitate an attractive person could confound the intended outcome of an AIDS prevention message if the character engages in risky behavior. For example, one girl commented that the video character Crystal was "a little tiny bit" similar to herself. She explained that Crystal "was like seductive when she first came out. When she slept with him, she was aggressive."

For other teens, however, an attractive person may need to garner respect or be homophilous with audience members before he or she could be seen as a role model. For example, one girl said she did not admire Crystal's behavior, arguing that the character was "different from me 'cause she's the wrong age. And she was too nasty."

An awareness of potential "slip ups" can be learned through seeing consequences of others' mistakes. For example, the tragedy portrayed in the "On the Pillow" video

caused many focus group participants to reflect on situations that could lead to a fatal mistake in their own lives. One woman commented:

> Seeing how this mistake happened to this one woman who actually had given herself to him, that he received AIDS, and now she could have it and the baby could, too. It makes you more aware of it, and then you're going to be more easy to say, 'Wait a minute. I cannot have a slip-up, because it could take my life.'

Heritage reminding

Heritage reminding can be a tool for enabling African American teens to follow AIDS prevention recommendations. When a significant other advises a teen of his or her racial background, in order to promote a sense of pride in black roots and the need to appreciate it, this guidance can connect racial pride to issues addressing protection of self and others.

A key component of black heritage is the church. AIDS prevention projects targeting African American teens should include "a spiritual basis," one woman argued, "because the African American heritage starts in the church, and it will always be in the church."

One girl speculated that church is "more important in the black community because that's what our ancestors were brought up on." Another girl suggested that African American teens are more religious than white teens because their Christian values have been passed down from their African ancestors who endured slavery. She added that "during slavery, they had some Christian songs, and they read the Bible."

Another girl suggested that the African slaves' faith in God during their struggles for freedom could show African American teens how to cope with difficult situations in their own lives:

I learned in African American history that we used that as a way of dealing with situations, letting God lead the way of getting out. 'Cause slavery was bad, and it was always an escape.

When slaves worshipped God, another girl added, it was "how they let their emotions out." Worship, then, may serve as a spiritual connection to a higher being, an intellectual connection to slave roots and form of heritage reminding, and as an emotional connection to an individual's own everyday struggles. These connections, in turn, possibly could help empower African American teens to postpone sexual involvement or to otherwise protect themselves from HIV infection.

The concept of "protecting the blood" has been used in national AIDS prevention campaigns targeting African Americans. It implies that African Americans of all ages should look out for one another because of their racial ties and shared heritage.

Warning others if they are in immediate danger of contracting the virus is one way of "protecting the blood." Several focus group participants said if they got AIDS, they would publicize the HIV status of the person who gave them the virus. For example, one woman said she

> Would have it broadcast, have it printed, anything – this man has it. You know, I was ready. He gave it to me. You know, that way, the next woman he hit at say, 'No, no, no. This girl said you got that. Uh-uh, I don't want that.' And like, 'They was showing us both the rumors.'

African Americans should unite to protect and comfort their black brothers and sisters who suffer from the disease as well. One woman commented, "You've got to say it, 'They're black. They've got this. We're going to help them.'"

Achievement orientation

Talking about future plans for success is one strategy that adults can use to encourage teens to protect their health while they are young, argued one woman who does not have children of her own:

> I guess if I had a kid, I'd probably be like, 'Is this what you really want to do? Why do you want to do it? Why is so important to do it right now?' I think I'd probably hit career, future. I mean, that's a chance to tell them about AIDS and other things that are out there.

Giving teens a vision for the future also can help them make more rational decisions while they are young, a key informant said. She contends that when youth are given "the vision and the dream of where they're going, the decisions about themselves will be automatically clarified." When talking to her own children, the woman explains it this way:

> 'If you don't have a degree, you might not get any further than $5.25 an hour. You're going to have a hard life, all of your life. You cannot look at the cars driving along the road. You're looking at it now. But when you become a full adult, there may be cars floating in the air. Envision what your children will be doing and how they will live their lives. If you can't visualize them living in space, then you can't make it there now. 'Cause that's where we'll be. In order to be a part of that, you want to live. So you have to make the right decisions now that will affect how you live in the future.'

When asked what they wanted to do when they were older, most boys and girls said they wanted to earn a graduate degree in order to have a professional career. A professional basketball career was a common aspiration among the boys. One boy in the pilot focus group commented that he wanted to be a doctor, lawyer, or a professional football player.

Most girls said they wanted to become professionals. Their career choices included that of doctor, teacher, nurse, lawyer, veterinarian, and judge. One said she

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wanted to be the first woman president. Among the few girls who named non-professional choices -- mother, spiritual dancer, model, and cosmetologist -- all listed these vocations as alternatives to a professional career.

"Making it real"

The use of intense imagery or personal contact with patients may be a necessary but not sufficient factor in persuading youth to practice AIDS preventive behaviors. A woman living with AIDS, whose infected daughter died several years ago, said that bringing youth face to face with a person living with the disease is not too intense for any age group, "not when it's dealing with life. But I can say that 'cause I'm dealing with this." However, she questions why her own 17-year-old daughter became pregnant through unprotected sex after witnessing the suffering and death of her younger sister:

> She's seen it intense. She's seen my daughter in the hospital with tubes and all of this, and she knows I'm HIV, and she still goes out and gets pregnant. How could she do that?

A number of women nevertheless argued that AIDS prevention efforts will not "hit home" unless they show how people suffer from the disease. Several women recommended taking teens through an AIDS ward to show them the seriousness and severity of the disease and to promote compassion toward people living with AIDS. One woman commented:

> I think that you should take them through an AIDS ward and let them see how people suffer -- not trying to scare them, but to let them know what reality really is. If you took some teenage kids, starting middle school age, and let them see how people suffer from AIDS and everything, I think that would hit home.

This strategy might prompt criticism from some parents, who do not want their children to be frightened or physically exposed to a diseased person. One woman defended the hospital visitation idea, saying:

Some people might say taking them through a hospital is too hard on them, but it's harder for them to go out there and get it and then have to find out all of this. It's better to educate them. I don't care what the cost is.

A female pastor said she plans to invite a person living with AIDS to speak to her congregation to let them "know this is not just something you see on television or in a movie. This is real life."

One woman said her three teenage daughters learned about AIDS firsthand by experiencing a cousin's death from the disease. She commented:

I let them see the point where she had to go into intensive care with an aneurysm on her brain. I mean, they went through the whole thing with me. My kids got to actually be there to see the things it put my cousin through. It lets them know it's real. It's like teaching them about alcoholism by taking them to a morgue to see kids who were killed by it.

"Making it real" for teens involves showing them how others like themselves have contracted the virus, one woman argued. She explained:

Even if you and your friends are talking about sex, but you're not actually doing it, you still don't think, 'It can happen to me.' 'How can you tell me I can get AIDS, when I don't even know anybody that has AIDS? I know other kids who are having sex, and I've never seen anybody that had AIDS except a gay person.' It's gonna have to be real to them. It can't always be just us sitting there telling them.

Many teens and women argued that the most effective way to educate others about AIDS is to bring them face to face with a person who lives with the disease. Many individuals who secretly live with AIDS may want to come forward to educate others about the disease but fear the consequences of stigma. One woman observed:

Those are the main ones who can be the most effective. They're the ones they can see, that can speak and say, 'This is happening to me. Look at my body, look what's happening to me because of this.'

A male minister said he uses true stories to address AIDS in his sermons. For example, he once told a story about an acquaintance who committed adultery, contracted HIV, and then infected his wife. He said many people relate to true stories because

> this is live, this is documented, this is true. I'm not telling you a fairy tale or something make-believe. It makes you more aware of a situation when there are actual events. We're not talking about someone in a magazine, but someone standing before you who's really lived through this experience.

Dialogue about AIDS

Education is a necessary but not sufficient condition to promote preventive behavior, and open dialogue about AIDS may be more important than education in sustaining healthy behavior patterns. One woman remarked, "There's a lack of education, but communication lines probably need to be open more." Even though none of the families in his church appear to be directly affected by AIDS, one male minister said he has a responsibility to deal with AIDS, because this kind of discussion is

> Another way of saving lives, not so much spiritually but physically. To not address it or talk about it or discuss it could put somebody else in jeopardy. So, to skirt over it or hide it or pretend that it's something that's not going to really affect our church – I think that minister or congregation would be doing them a big injustice. That would be a big mistake for them to not talk about it.

Even though none of the families in his church have been touched by AIDS, this minister said he has mentioned the disease in his sermons

> More as information, not so much as a scare tactic, but as preventive teaching – that it's the result of something that can happen if you're not careful. It's almost like you're going to be faced with the bad if you release yourself to the dangers out there.

Although his congregation is generally open to discussing AIDS issues, the minister said they do not talk about it enough:

We don't talk about prevention enough, things you can do to educate people. We are aware of the disease, but I don't think we talk about it among ourselves enough. I don't think any church would say this is the focus of discussion.

In a follow-up interview, conducted six months after the research ended, a key informant said that her involvement in the study led her to conclude that

If AIDS isn't brought to the whole church, they may not see it 'cause people don't take it seriously. Every church should have a focus group to discuss these issues. There's a great need for it.

In the girls' group, the only people they recalled talking to about AIDS were parents, most frequently their mothers. One girl said her mother "told me a true story about a girl that got AIDS," and this conversation occurred after the girl told her mother that "we were learning about AIDS in school that day." Another girl said her mother initiated a conversation about AIDS "one night when we were talking about the human · body and sins and everything." The girl recalled that her mother "just talked to me, to be aware and to watch what I'm doing."

None of the boys said they talked about AIDS with a parent. One boy said he has had many discussions about AIDS with others, including talks with his friends, cousins, parents, and pastor. Another boy remembered that his pastor had talked to him about AIDS. Although most boys did not recall having a conversation about AIDS with anyone, many remembered hearing a classroom presentation by an HIV-positive woman.

Another form of open dialogue about AIDS is discussion in the context of a romantic relationship. Couple dialogue has been promoted in several different national AIDS PSAs, including the CDC's "Know Your Partner" and "Respect Yourself, Protect Yourself" campaigns. One boy was aware of this advice, commenting that a person is more likely to get AIDS "if you do it without having a conversation."

Dialogue about sexuality

Many youths may find it too difficult to initiate a conversation about sexual issues with an adult. For example, if given the chance to talk to her pastor privately, one girl said she would prefer to discuss family conflicts rather than sexual issues:

> I'd probably talk more about a problem I'm having with my mom. Me and my momma be having an argument.

When youth do muster the courage to start a conversation with a parent about sexual issues, often the parent responds with shock or disapproval. Often the first mother-daughter discussion about sex occurs when the daughter wants permission to begin using birth control. One woman recalled her shock when her daughter brought up the subject of birth control pills:

> My daughter came home, my baby girl said, 'So-and-so giving her daughter birth control pills.' I almost fell dead. I say, 'Giving her birth control pills? What are you sayin'?' She said, 'Well, I thought if she's taking birth control pills, I can take them.' I said, 'No, ma'am. I ain't giving you permission to take no birth control pills. I feel like that's like giving you consent to have sex. It's time for us to really have a talk.' By the time I hit the ceiling and panicked, I almost fell dead. 'Cause I didn't quite understand it. See, when a child say something, you need to really listen. If you didn't quite get it, you say, 'What are you sayin'?'

Another woman related having a similar reaction when her daughter requested permission to use birth control, but this mother did not promote open, two-way dialogue about it:

> My daughter was sayin' to give her birth control. But I really prayed about that. I told her what the Bible says, and I said, 'If you sneak and you do it, protect yourself.' I don't need to know anything about it, but you sneak down to that clinic and get what you need, or you'll sneak and go get a baby.

Given that teens may be reluctant to initiate conversation about sex with adults, the adults may have to make the first move. One woman recalled how her own mother initiated discussions about sex:

I had a friend that got pregnant, and my mom came to me. She was just like, 'Do you want to get on the birth control pill now?' And I was like, 'You know we've had this talk a million times. I've told you I ain't doing that.' I wanted to talk to her because she wanted to talk to me.

One woman commented that being open with her children sometimes can be "tough and awkward and weird." Sometimes listening to teens involves willingness to non-judgmentally accept their confessions. As a mother, one woman said she has

learned that to communicate with my kids, it's gonna be some things that you're not gonna want to hear. It's not always gonna be good. If we think back to where we was, and some of the things we snuck and did, then we can understand.

Authoritarian lecturing and scolding are not effective methods of promoting "correct" behaviors among teens, one woman argued. She said teens expect a parent to give them a reason for behaving a certain way, and if the parent does not provide a reason, "somebody else will." Another woman commented:

What's wrong with a lot of parents now is how much you stuff things down them and tell them they cannot do it and what they're not supposed to do, all the time.

Showing love and acceptance is a better approach in the long run, one woman argued. Reflecting on her own childhood, she recalled that her mother

didn't shove it down all the time about 'Don't have sex.' And some people thinking it's just by saying, 'No, no, no' that that's what it takes. It's not so much the 'no's' but it's all that love and the other things that's planted in you that help.

Parents must deliberately establish relationships with their children and work to maintain those relationships, a male minister argued. Keeping an open line of communication between parent and child is an essential means of preventing a child from making serious mistakes. The minister commented that "someone may be pressuring them to do certain things, and you'll want them to come and really talk to you about it."

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He said he tries to communicate to his children the message that "I don't want you to make a mistake because you feel that you have to do these things."

Given that communication styles among youth vary widely, parents must adapt to these individual differences. One woman observed that "it's not so easy for everyone to be open. You know, every child is different." Regardless of individual differences among youth, however, a supportive approach will be effective

> as long as you're trying to be open enough that come what may, you've been there, and you're not gonna kick them out of the house. You know, 'Use your head like I taught you, and I'm here for you, whatever.' I think that's so important in the long run.

Talking about behavioral intentions may be an essential part of an effective discussion about sexuality. One woman suggested that "one thing we need to talk to our children about, is they can have good intentions but if they don't go all the way with it, it doesn't mean much. They intend to do something, but they don't do it."

Telling "our stories"

Many African American women are key resources for carrying AIDS prevention messages to youth through the oral tradition. A key informant recalled that when she and an AIDS network outreach worker conducted an AIDS workshop for a Christian women's convention, all the participants were grandmothers. When the two workshop leaders presented information about AIDS to the group, the response from these older women was overwhelming:

> You would not believe the energy they had. They were so excited. They heard stories about AIDS, testimonials, and they asked questions. They are an untapped resource. We were really excited by doing that with that group, and we'd like to see more of that. They are the real teachers. Children have a way of really wanting to know, to learn, to understand their boundaries. And they listen.

Sharing personal stories about the challenges of growing up is often an essential part of open parent-teen dialogue about sex. In reflecting on her own experiences in helping her daughters, one woman commented:

> Sometimes, and not just sometimes, we need to tell them our stories. Not necessarily that they're going to broadcast it. They're not going to do that. But you need to tell them your story. But you know, 'Momma got pregnant when she was 12, but I know I could not do this. And I should not do this, and this is how my parents raised me.' That sticks, believe it or not. That really pulls them through, if they're 16 or 17 years old – the stories that you have. So it's very important that we tell the stories to our daughters that will help and aid them.

Another woman said that when she was young, her mother shared stories about becoming pregnant at 16. The woman said this kind of parental honesty really helped her make sense of her own circumstances, such as "when you share what you've been through, and even how, 'OK. I did it, and I messed up.'"

Sharing personal stories as a tool for counseling young people is not limited to parent-teen dialogue. A woman from a low-income housing area said she often walks the streets so that she can tell young women about her own past mistakes. She explained her strategy this way:

> When they come up to me, they say, 'Girl, let me tell you something.' They think I've never really been out there, and I don't know what they're going to come to me for. It's an old game. I just tell them, 'Let me tell you a little something. I used to be just like you, walking around with my big hand on my hip. Well, look at me now.'

This strategy is not only valuable from an adult perspective. One girl said she appreciates adults talking about their past experiences. If presented the opportunity to talk to her pastor in confidence, she said, "I'd want to know what they went through."

Communication skills training

To help address barriers to effective parent-child communication, many participants in the second women's focus group discussed the idea of initiating a communication skills workshop for parents. An argument in favor of this idea is that many African American mothers are single parents who must work to support their families, and this situation leaves many children unsupervised and free to roam with their friends most of the time. Time spent apart can widen a rift between children and parents, especially when parents try to enforce discipline.

One woman explained that since she "had nobody to teach me," she reaches out to young mothers to "tell what I've been through."

The focus group itself was suggested as a model for a parenting class. One woman suggested that "if you bring a parent into a group just like this here, it helps the parents know exactly what to tell their youngest children." Another woman suggested focus group sessions in the public schools, in which parents and children could meet together for discussion and training.

One woman pointed out that many African American women living in housing projects are beginning to enter the work force through a government-sponsored transitional program. She suggested that these women be required to take a parenting class or AIDS communication class in order to qualify for assistance through this program. She explained her rationale:

> It needs to be part of that channel, during that approval time, to teach them that type of communication so they can interact with their children. 'Cause those are the younger ladies that have the kids, that just throw them out there and go on to work. It might be a beginning point to teach mothers how to talk with their children, even as young as 2 or 3. We could also get their input.

A male minister said many adult church members can serve as role models and as friends for youth, and many adults have the resources to "offer some other outlets to the kids so they won't think that 'Well, I don't have anything else to do.'" He said serving in these roles requires a person to be creative, involved, organized, and active:

> You've got to be willing to hang out when you get older because kids stay up late, they want to talk, so you can't shut them off and say 'It's time for me to go to bed, I'm tired.' You've got to do some things to keep them going and let them have their space where they can enjoy themselves. You have structure.

A male minister suggested that role playing could help church members of all ages learn how to communicate with each other about AIDS prevention issues, so that "children won't be so naïve and gullible, thinking 'What's going on here?'" He said adults have a responsibility to think about their child's sexual development, and sometimes he asks parents questions such as "What are you going to do?" and "How are you going to handle it when you are approached?"

The "right atmosphere" must be created before open communication can occur between adults and teens in his church, one male pastor observed. For example, one day a year the girls in the church are invited to join fathers from various churches for an outing called "Daddy's Day Out." This event is designed to create an atmosphere for girls to talk to men who can serve as their role models or father figures. After the minister forms several small groups, he explains to the girls

> The focus of why we're here – that we want to be here for you.' They can ask those questions that they've always wanted to ask but maybe were afraid to and have a heart-to-heart talk. Their dad may not be the one who's leading the group, so that makes it easier for them to open up. Sometimes kids have a hard time opening up to their own fathers.

The minister observed that some youth in his church do not have fathers at home, even though most have regular contact with their fathers. The "Daddy's Day Out" event

helps fathers learn to communicate with children by approaching dialogue from the perspective that "'if anything comes up, we don't want you to ever be afraid that you cannot come and talk to us about what you're going through,'" the minister explained.

Dialogue tools

Although the focus groups in this study were used to gather data about attitudes, beliefs, ideas, and behaviors, the groups themselves appeared to serve as a tool for promoting thought, awareness, and continuing dialogue in a non-threatening setting. The moderated, semi-structured focus group also might be used within churches as an AIDS prevention tool. One woman commented:

> I'd just like to see if there could be something done in the church, where you wouldn't have to point the individual out. Just like we're doing here now – making people aware of it, and how it can happen, and how easy it can happen. You know what I'm sayin'? And it don't have to be any special individual that it can happen to.

Despite her initial resistance to come, one woman reflected on her new level of AIDS awareness and knowledge that she had gained through participation in a focus group:

> Tonight my sister told me we're going to this AIDS thing, and I said to myself, 'Oh, I don't want to go to that.' And I actually looking for reasons to get out of this. I'm really glad I came, 'cause I really never went to discuss or learn too much about AIDS, no more than looking at TV, you know, when they talk about it in church and stuff like that. This is actually my first time ever being out to discuss what you should do. Like I've got five boys, so I really do need to be up to date with everything. And I'm really glad she got me to come out tonight. It do put a lot of thoughts in your mind – what would you do?

In addition to the "Afternoon Delight" *fotonovela*, the "On the Pillow" video was used to promote focus group discussion through raising awareness about AIDS-related issues. One woman commented that after seeing this video,

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It makes a difference to me. It made me more aware that it's not just an unfaithful person that does this all the time. All it took was one time. And that was enough for me to know that we need to show people, to let them know.

Empowerment of African American adults

African Americans must be empowered through unity, concern, and a common vision if they are to help protect youth from HIV infection, one woman argued. This goal will require long-term effort. A key informant from the Task Force contended that African Americans in Gainesville need empowerment because many

feel like they've been left out of the system. They need to know and feel the support of family and community. They need the basic tools to survive, but often they're too proud to ask.

One woman remarked that "we're going to have to work at empowering African American women in doing more." In response to this call to action, another woman examined her own efforts in light of others' needs:

That's why I work as hard as I do. I know I'm saved. I've been baptized, but I'm still reaching higher for myself, too. I feel like if I need help, I know that somebody else out there got to need more.

In exploring the concept of empowerment, one woman suggested that African American women put aside pride and defensiveness and participate in the kind of community parenting seen in many African villages. She suggested:

If we do like they did over yonder, where there was the community raising up the children, then we will watch out for other people's kids instead of saying, 'Now see, that's just a bad young lady,' and not say anything.
Building on that idea, another woman quoted the old cliché, "It takes a village to raise a child," and requested the assistance of her African American sisters:

I need you to help me. We have to go back to the realization that that's the way it must be, that you can go and talk to my daughter when you see her prancing around with a little boy, 'Well sweetheart, I know this is not you.' And know that the mother is not going to be offended.

Finally, one woman proclaimed: "Let's take the neighborhood for our mothers!"

Watching out for others' children does not imply that all parents are negligent, one woman argued. Rather, community parenting is a way of assisting parents with the impossible task of monitoring children when they are not at home:

> Let's help that parent by us watching out, us looking out. Their parents might be doing all they can to tell them, but maybe they can hear it from somebody else or hear a testimony about something you did. Once that becomes a reality to them, I found out a great tool is just being able to listen to them, because we get so busy and we don't listen. All they want, the majority of them, is someone to sit down and talk to them.

The empowerment to stop the spread of AIDS does not necessarily depend on collaborative efforts, one woman argued. She recommended that every person

> just reach out and do what we can as one person, and not waiting until, 'OK, we gonna wait 'till we start this big group up to do it.' Let's do it before then. If it's not going on in school, or it's not going on in the churches, we as individual persons can do a lot more than trying to wait until you got a group to do it.

This woman said she talks to many girls individually about their personal concerns. She recommends that other women develop a sensitivity to "signs" of trouble that girls sometimes show and reach out to help:

> We can stop, and every time we see a sign, we see a young lady in church, we see them things, we can sit down and show them we care."

When one woman was growing up, her mother became a godmother for many of her friends who could not communicate with their own parents. "It got to the point where my friends, my cousins couldn't talk to their momma. And they'd be like, 'Can I come talk to your mom?'" A barrier to this commitment to community parenting is a common mothers' attitude that their children have had superior upbringing that will protect them from harm. One woman observed this widespread attitude:

In our churches, homes and community, most people have gotten to the point where, 'My child is better than yours.' Or 'I don't have to worry about this, because it's my child.'

Empowerment of teens

While women need to be empowered to protect each other's children, the youth need to be empowered to make their own decisions about sexual involvement, one woman argued. Reflecting on her own childhood, she commented:

My mom wasn't always saying, 'Don't do it, don't do it, don't do it.' 'But you have a mind of your own, and this is not going to make or break you. You gonna be up for this at some point in your life.'

A female pastor said she tries to help teens cope with peer pressure by talking to them in small groups. She said a primary lesson is "how to be your own person and not be a follower." She tells them that "it's OK that if you don't like something you don't have to go along with it. You don't have to let people persuade you into doing different stuff." A related lesson she emphasizes is that teens should have the courage to stand up for their beliefs:

It's just as well as it is for a person to have their own religion or to say, 'I don't want religion. I want to live this way.' You have just as much right to say, 'Well, I don't want to live the way you're living.' I say, 'What about the drug addict that's selling drugs? He'll come tell you all about it, and that's something that's going to kill you.' So you should learn to be not ashamed of who you are and what you believe in, in standing up for that. Learn how to read and get educated for yourself about whatever you believe in.

Teens are the best suited to educate their peers, argued one key informant, because they are well educated about the risks, but they also understand the curiosity and urges that motivate youth to try risky behaviors anyway. She observed that most teens

want to know all the risks, the consequences of their actions. It's available to them. They know they can reach out and touch it. Yet, there's a component of it that's just being a teenager – they must try the risk. And we have to understand that they will try it.

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Compassion

The behavior change strategies used in compassionate Christian outreach could be effective in promoting AIDS preventive behaviors among the African Americans who are most at risk of infection. This approach to behavior change involves social support, helping individuals improve their perceived self-efficacy, and promotes open dialogue.

One female pastor argued that Christians must foster a non-judgmental attitude towards non-Christians before they can engage in effective outreach. The people targeted for outreach must be supported and validated, even if their behaviors are sinful or unhealthy. The pastor said that she and others in her church invest much time and energy visiting residents of low-income housing areas to help them overcome bad habits:

> We don't believe in a lot of different things that people do that are wrong, but we deal with them because it's life. They don't fit in, so that's why they hide it. A lot of times we get people to open up about things that they usually wouldn't open up to other people about because they know that we're not going to judge them. We're actually going to go from where they're at and see what we can do to help them. It's not that we accept it, but we accept them and then we try to help them to grow above those problems and minister to them instead of just saying 'OK, you're not a Christian if you're like this' and then throwing them out the door.

This kind of outreach reinforces the message that Christ's love and healing can empower individuals to overcome their problems, the pastor said. Many people approach her for guidance after they have experienced a personal tragedy. She said that showing unconditional love proves to people "that we're legitimate and that we're not just trying to get numbers for our church and different stuff like that."

When she visits the residents, she tries to create honest dialogue with them about their problems and concerns. The pastor described her approach this way:

> Once you sit down with them, they begin to talk. All they want to know is they got somebody that cares and also that they can be confidential with us and know that it's not going to go out, but that we're going to sit here and we're gonna pray

as long as it takes for them to get better or whatever, and not just throw them away. What happens is once they get to know us, then that's when a lot of this stuff comes out.

A key informant said her church is accepting of unwed teenage mothers, even though most African American churches in the past would not have been so supportive. She told the story of a high school senior who became pregnant, and her church helped the girl graduate and become a successful university student:

People surrounded her with love, and she brought that baby along because that baby's not a sin. That mistake didn't stop her life. If there was no love and compassion, she would be a casualty on welfare. Churches have come a long way, and we've done a great job not being so judgmental when a young lady does have a pregnancy. She is not told she cannot come to church because she can be a productive part of the group. If one life is strong, then two lives are strong.

The woman commented that she would not be able to assist people living with AIDS if she did not foster a spirit of forgiveness toward them. She said:

I'm not judgmental, but I don't think I could work with them. There's a bumper sticker that says, 'I'm a sinner, saved by grace.' But in our weakness, we have to help each other and feel compassion for each other and love each other to build that person up.

Reinforcement of religious values

A key informant argued that AIDS prevention efforts in the black community may ultimately fail without leadership within the churches:

Our main background in the African American community is our churches. And it appears that if we don't have the leadership of our churches, we cannot fall on the background of our family. Because it's just inherent – our family and churches are connected.

Parents who want to help protect their teens against consequences of peer pressure should show trust in their children and teach them Biblical principles that can guide their behavior, one woman argued. Reflecting on her own upbringing, she said:

I know that my mom, she did not tell me all the time, 'No, don't have sex' and all that. But she gave me the Word of God, she told me what God said, and that was it. And she trusted me. My friends, I was with them every day. Their parents were Christians and had told them they couldn't do it. But as soon as they went to bed, they were sneaking out the window. And I went right along with them, but I would not let a boy touch me. I was a virgin before I met my husband, and I was proud of it.

Instilling Christian values through open dialogue and Biblical training may help prepare younger teens to rationally and confidently cope with peer pressure. One woman explained:

If they learn those values, it will help them to understand, even when they get old enough for peer pressure, they will feel strong enough that they can stand and say, 'Well no, I'm not going to do that without feeling like I've got to be persuaded.' Because they'll know the reasons why they're not.

The religious norm of confessing sin to a minister can support a system of accountability among individuals, such that a minister can help a person involved in risky situations to make behavioral decisions in a more rational or moral way.

In evaluating the "On the Pillow" video, one woman commented that although Terrence made a mistake,

At least he went to someone in authority to confess. And he didn't just keep going on, like it could have been a chain reaction if he had not went to his pastor. So to me, I thought that was a good point of view -- that he was mature enough to do that.

If spiritual counseling can reinforce individuals' religious beliefs, it might persuade them to avoid risky behavior. For example, one woman argued that counseling "makes you aware of how much that one mistake as husband and wife or whatever could not only hurt them."

Finding theological commonalities among various African American churches, in terms of how those beliefs could support open dialogue about risky behaviors, could

encourage many concerned members of the larger community to rally behind the AIDS prevention banner. A key informant suggested that the dynamic power of uniting the African American churches to fight AIDS could help strengthen a broader community campaign.

Female opinion leadership

Six months after the study ended, a key informant commented in a follow-up interview that an important aspect of a church-based AIDS prevention program would be to "let the women in church know that they have to take responsibility" to help themselves and their children. She said she's heard some women say that they wish they had been involved in the study because they wanted to be involved in the problem-solving efforts of the women's focus groups.

A male minister commented that many women in his church are influential and willing to talk to youth about sexual issues. Although the girls likely would benefit from this kind of dialogue, he said, "I don't think the boys would feel comfortable going to a lady."

However, when he was a boy, this minister sometimes sought advice from women in the church, especially the "older people who were like role models." He said that sometimes he "felt more comfortable talking with men, especially if there were things you might call sensitive." The minister said he looked for role models in the church because he was not comfortable discussing sensitive matters with his father:

> Not to a point where I could go and sit down with my dad and say 'Such-and-such is the case.' I'd probably get it out eventually after walking and pacing the floor. It wasn't an easy transition.

Although African American pastors tend to be reluctant to discuss AIDS prevention, the women who participated in focus groups and interviews and those observed in AIDS education settings were eager to learn more and frequently asked for resources, tools, and strategies to help initiate prevention efforts in the community. The following are typical remarks made by female focus group participants:

> We need to know what's the best way to be able to approach it. Now that we know about it, I think maybe we need some more tapes, some more literature. So how do we stop it in the church? How do we tell our young people?

A female pastor who attended the AIDS breakfast commented that the other ministers at the event "had a hard time dealing with it." She argued that if the ministers "don't want to deal with it," then African American women must realize that

> It's our job. If the head people do not do it, we've got to take it upon ourselves to look out for that young girl or young man that's going the wrong way.

Even if ministers refuse to talk about AIDS from the pulpit, women can take a stand to promote church-based AIDS education. Suggestions for AIDS ministry projects, offered by various women, included Bible studies, an AIDS missions night, discussion groups, video showings, and literature distribution. One woman commented:

> We need more people talking about it, more movies, more literature put out in the churches. It's gonna help not only the kids. But we need to reach the adults. They need to speak up.

Forging inroads

Although these kinds of church projects can be launched by influential women and other individuals, a comprehensive AIDS ministry is not likely to be initiated in most churches unless the minister perceives an urgent need that outweighs the possible political consequences. One woman remarked that "if we were able to employ the

ministers to take a more expectant viewpoint of the AIDS epidemic, then we can really get the program in the church."

"Inroads," a buzzword mentioned during numerous African American AIDS Task Force meetings, often referred to the group's quest for networking and innovative strategies for targeting hard-to-reach youth with AIDS prevention messages. A common comment by Task Force leaders was "we're looking for inroads" -- primarily inroads into churches, schools, volunteer groups, and other organizations.

The co-founder of the Task Force recommends that the group promote AIDS awareness through youth skits, videos, and community workshops. She suggested the idea of raising money for a college scholarship as an award for the best AIDS prevention proposal submitted by an African American teen.

According to a brochure describing AAATF's primary goals, the organization is "seeking inroads to serve the church community through culturally sensitive AIDS programs and seminars, tailored to address moral and religious standards, which foster care, compassion, education, HIV prevention, training, information, and referrals."

In their attempts to forge inroads within African American churches in Washington, DC, AIDS prevention specialists from the national Agency for HIV/AIDS have developed a basic outreach strategy. Jean Tapscott, an administrator with the national Agency for HIV/AIDS, explained:

> First, you need a core of ministers who are receptive. Many people don't want to be identified with AIDS. So instead of addressing AIDS head-on, you can have seminars that cover teen sex, health or violence, or have general health fairs with AIDS awareness as an element or component. You can only give them as much as they can handle, but you have to find out what they can handle.

The mission of an AIDS ministry should theologically dovetail with the traditional mission of most African American churches, Tapscott argued. In describing the approach to AIDS ministry promoted by her agency, she commented:

> The philosophy of this office is that churches should do what they usually do – minister to physical needs and spiritual needs, provide compassion and caring and a message of prevention. Sick people should be treated the same, whether they are HIV positive or not.

Tapscott has observed that African American churches are more likely to collaborate with an AIDS organization when someone within the agency has strong ties to the religious community. She commented:

> There are issues of church and state, but there can be a good marriage between church and state. Right now, many churches and agencies seem to have pieces of the whole, through their individual efforts, but where do you pull it all together?

Her agency met resistance when it attempted to introduce literature about condoms and sexual issues within various churches in the city. Tapscott said the Religious Roundtable "didn't want to use words about condoms and sex. So we took those words out. If that's palatable for the church, then that's fine."

The nature of inroads for AIDS ministry depend upon whether initiatives are intended to function as education or ministry for people within the church or as church-based community outreach. The political climate within a particular church may determine which initial approach is most appropriate.

While most African American churches are not willing to promote condom use within their congregations, some apparently are willing to distribute condoms to prostitutes or other at-risk populations as part of an outreach ministry. This irony was observed by one key informant, whose church is theologically conservative:

Here's the Litmus test: you could interview other people from my church and ask, 'Did you pass out condoms?' and they'd say, 'Yeah, I passed out condoms.' 'Did you give one to your own son?' 'My son? No. He ain't going to be doing that.' Or here's a good one: 'Did you give some to your daughter?' 'No.' They'd go down to the Salvation Army or Saint Francis House to pass out condoms. By all means. Going down to where the prostitutes hang out -- I call it the zone for prostitution over there -- fine, pass them out. Over there by the Greyhound bus station, they ought to be passing out condoms every night. But pass them out in church? I doubt it.

A female pastor said she wants her church to be the first in Gainesville to develop an AIDS ministry. She wants to start by hosting an AIDS week that would include a guest speaker who is an African American person living with AIDS, a healing service, and possibly a benefit concert. Her church, an interdenominational, Pentecostal, independent congregation, recently purchased a school bus to pick up residents of housing projects for transportation to church services and other events. Given that many church members and visitors "probably have been drug addicts and alcoholics and stuff like that," AIDS awareness events should be designed to "let them know why they don't want to go back out there to that, because of what can actually happen."

In recruiting people living with AIDS to serve as community speakers, churches and AIDS organizations must sensitively and strategically consider the personal consequences that the speaker likely would endure as a result of going public. For example, an African American woman living with AIDS recently decided she would like to serve as a speaker, but she is afraid to take the first step in Gainesville for fear of verbal attacks upon her and her children:

As far as getting on TV or something, that would give me a heart attack. I'd have to go to a whole different county 'cause my children have a problem. One time the AIDS network asked me about going into the schools, and my oldest daughter said, 'Momma, no!' 'Cause they had some other people come to speak, and the children asked them all kinds of crazy questions that made no sense.

Reflecting on her own experiences, she suggested that a starting point for an

AIDS ministry in some of Gainesville's black churches could be a simple information

campaign:

> The best thing possible that can be done right now is to let people who have HIV
> or AIDS know that the ministries are there. It's up to the person to actually come
> to them with it, 'cause a lot of people are sitting in the closet. Put information out
> there for people with HIV, so they'll know where they can come if they need to.
> The churches just have to sit back and wait for those people to come in. They
> need to say, 'Come here and let us pray for you. Come here and let us help you.'

Community education is another form of church-based AIDS outreach. An AIDS

awareness fair in Washington, DC, the collaborative effort of several African American

churches, demonstrated a level of institutional unity and compassion toward people living

with AIDS that has not been seen in Gainesville. During this four-hour event on a sunny,

humid morning in August 1995, health educators and representatives from three churches

and various service organizations manned a dozen tables on a barricaded inner-city street

within an African American neighborhood. While teens played basketball and families

shared hot dogs, lemonade and grilled hamburgers, church leaders passed out literature

and small groups discussed AIDS concerns in the midst of the festivities.

Kevin McDermott, director of the HIV/AIDS Ministry of Greater Mount Calvary

Holy Church in Washington, DC, coordinated the event. Although his church is not

involved in street outreach, it coordinates AIDS fairs that provide referrals for and from

other organizations in the city. The church also is seeking federal grants to fund

construction of a substance abuse rehabilitation center that will develop HIV education

interventions for its clients.

Greater Mount Calvary and other African American churches in Washington, DC,

have been among the first in the United States to initiate AIDS outreach projects within

their neighborhoods. Tapscott said these projects have included church posters with an abstinence message, church bulletins devoted to AIDS awareness and information, and bus posters, as well as TV and talk show programs. Several churches have produced public service announcements for newspapers, television, and radio, with messages that promote abstinence, HIV testing, and prenatal HIV testing, as well as messages that emphasize "the church loves you."

African American churches can develop projects to coordinate with annual events such as AIDS Awareness month in October or World AIDS Day on December 1. Tapscott said African American churches in Washington, DC, have coordinated prayer meetings, benefit concerts, candlelight vigils, and other events to commemorate World AIDS Day. Her agency has found that an African American church is more likely to participate in these kinds of events if an African American person living with AIDS initiates dialogue with the pastor and congregation first. In addition, she said that "it helps if the church gives the person a gratuity for speaking, to help them make ends meet."

Greater Mount Calvary Holy Church in Washington, DC, celebrates AIDS awareness month by hosting an all-day, outdoor health fair, workshops, a Sunday evening healing service in which a speaker talks about healing and AIDS, and a Saturday night AIDS symposium in the church. McDermott said the symposium is a panel of seven or eight people that usually includes a person living with AIDS, a health educator, an AIDS case manager, a doctor or nurse, and a legal expert. On one evening every year, the church hosts an AIDS benefit concert that highlights musical talent and inspirational speeches from members of several metropolitan churches.

The AIDS ministry of Greater Mount Calvary Holy Church was perhaps one of the first in the United States to be implemented within an African American church. McDermott said the vision for this ministry was born in 1989, when the bishop became "troubled because several men had died of AIDS in the church." The bishop founded the AIDS ministry the following year while serving as deputy director of the National AIDS Network. McDermott remarked that the concept behind the AIDS ministry

> is to bring together everyone who has to deal with HIV issues and give them a place to get away from the pressures of dealing with AIDS, a place to be encouraged and strengthened.

The AIDS ministry set out to address community and congregational needs within areas of education, care, compassion, and outreach. McDermott said programs have included peer education classes, as well as hospital and home visitation, support groups, and prayer for people living with AIDS.

Community unity

The theme of the first AIDS prevention campaign initiated by the African American AIDS Task Force in Gainesville was "Umoja Sasa," which is Swahili for "unity now." The Task Force has distributed several hundred brochures with this theme.

The fabric of the African American community is torn bit by bit when children are victimized by AIDS, crime, and early pregnancy, one woman argued. She called for community action to solve these problems:

> You see a child got murdered, shot down in the street. That affects us. It goes real deep. And when we see our little babies pregnant at 11 to 12 years old, that goes real deep. That's something we don't need to let go unattended. That's something we need to be right on top of.

One woman argued that AIDS awareness and education must occur within many different segments of the community before the spread of the disease can be halted:

It helps for parents, relatives, people in school to be educated. It's not ever too many people to help -- to keep it in their minds at all times that these things can happen, so the more people that actually know how to educate people on it, the better they'll stop it from happening.

In the Gainesville area, African Americans should join with Hispanics for a more holistic approach to AIDS prevention, a key informant said. She commented:

I see more Hispanics coming in. I believe the cultural diversity will not be a long string. It will be a short one. I think we will be a more dynamic part of a total picture and more of a bonding there.

Social support for people living with AIDS

Social support, when framed as compassion, is a basic tenet of most African American church doctrines. When asked how doctrines of his church address AIDS education or outreach, one male minister could not recall any official statements that directly addressed these issues. However, he said his church is part of a network of interdenominational congregations that promote outreach to people of all backgrounds:

We talk about reaching out to all people, all men, all women, all over the world, but we don't limit it and say we'll only reach out to the people who are going to be down the Riviera. We reach out to those who are in need. We have a song, "The Lord is Within You" that says we are to go forth because there are millions who are waiting for ministry. Not just African Americans. Our scope is world-wide, and it's not limited to certain groups of people.

Beyond this global outreach mission, the church believes that people living with AIDS deserve compassion. The minister remarked that "love is universal. If it was conditional, then we'd really be messed up. That wouldn't be church."

Providing social support for people living with AIDS is considered a responsibility for a true Christian. As one woman commented, "I feel like as a Christian, the first thing that we should be able to do is to be there for them, and support them and to show love, and not to be so scared."

This woman further argued that although the African American church as an institution largely has failed to provide material assistance to people living with AIDS and to their families, individual Christians urgently need to provide this kind of support:

> The sad part about it, is it's not just the individual but the children, the whole family. They need to be supported. They're in and out of the hospital. They need money. They need food to eat with. It's just so much that goes along with it. And when that loss comes, it's not just to that person. Even though they have families, the families are not there to take the kids, and no one else is there to clean and cook and do for them. I've seen them. They're struggling, trying to feed their kids. They're trying to cook, and they're trying to clean, and nobody's there to help them. That's my worry more than anything. Where's the people who can actually be there to assist and help them?

Before effective social support can be provided, one woman argues, individuals must personally see the situation and feel empathy toward the needy person:

> The thing is, you've got to get people where right now they see it. So they can say, 'OK, I know she has AIDS, and yeah, I'll go in there or clean her house and cook her kids' food and do this and that, without the fear that I may catch it.'

Given that fear of contagion is a major obstacle to providing social support for people living with AIDS, she argues, helping people overcome this fear can be accomplished through education about AIDS transmission:

> You've got to get people involved, to know that you can go and hug her, and you ain't gonna catch no AIDS. I mean, it's the fear of the whole situation. So you've really got to sit them down and educate them. Then you'll probably get more help in these areas. You know, if this individual's got it, then you can say that 'She's got AIDS, and she really needs some help.' Then you've got people that will volunteer to do it.

After seeing how doctors and nurses were not afraid to touch and hug an infected young girl, a female pastor said she was less afraid to do the same. She observed that "some of the nurses were kissing on them and hugging them and just giving them love. And they weren't scared."

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When a friend was diagnosed with AIDS, one woman said this was the first time she had personally known someone who eventually died from the disease. Before the friend died, the woman felt helpless because "there's nothing you can do but sit there, hold their hand, and share the hurt with them." When asked the question, "How would you react if your best friend just told you that she has just tested positive for AIDS?" most women said they would offer comfort and share tears. For example, one woman said:

> It would be sad. You'd hug her. Y'all would shed tears. To me, it's not the time to talk. Nothing you could say or do could change that situation. So I would just let whatever happens, happen. Comfort her as much as possible. Or him. Make him feel all the love and that you're there with him through thick and thin. It just would be a very emotional time.

One woman, however, admitted that she would not be prepared to deal with the situation:

> You wanna know what I think? I don't know what I would do. Say, for instance if you came to me, and you told me you had AIDS, I wouldn't know what to do.

Developing empathy for the plight of a person living with AIDS is essential for the helping individual to offer genuine social support. As one woman observed:

> They can tell when you pull away from them, or you don't love them or be there to help take care of them. That hurts them more than the disease and knowing that they're going to die. The people that they thought would be there for them – everybody just disappears on them, and they've got to go through this by themselves.

Church outreach to people living with AIDS should include simple, everyday assistance, one woman argued. She said this kind of AIDS ministry begins with

> Some task, like who will want to go and get his medication for him, because he cannot get it? If you cook them one meal, they'll eat off that one meal all week. That mission usually goes out and 'This group is gonna fix dinner this week for Sister So-and-So, and if we need to go shopping for Sister So-and-So, we gonna

do that. We're gonna make sure she is fine until she is able to get back up on her feet.'

A major benefit of social support for people living with AIDS is that improved emotional well-being can boost physical immunity to illness. As one woman observed, "I think they last longer when they have a positive frame of mind. The mind is a powerful thing."

Within the focus groups, about one in three women and about one in 10 youth said they have personally known a person living with AIDS. In sharing anecdotes about their interactions with HIV-positive individuals, these focus group participants described their inner struggles to overcome fear of the disease and of the people carrying it. One woman said she overcame her own fears of contagion by showing compassion to a young African American girl who was hospitalized during the last stages of the illness:

> I know more about it from experiencing a little girl dying, and being in the hospital, and watching the nurses take care of her. That made me more educated, enough to know that I wasn't going to get it just because I showed her love or hugged her or gave her a kiss on the jaw. I've learned the thing they need most of all is love. Just to know that you're not scared of them and that the love you have for them goes deeper than whatever disease they may have.

Another woman first met a person living with AIDS at her workplace. After she learned that she could not catch AIDS through casual contact, she began showing a greater-than-normal amount of affection and attentiveness towards this young man while others were keeping a certain physical distance from him. She commented:

> A few years back, I worked with a young man that contracted AIDS, a gay guy. And he's very nice, very friendly guy. We always hug and shake hands. Now I know that you can't get it from shaking hands or hugging or just sitting down having a casual conversation. So I treat him like everybody else, but yet there's that hurt there where you feel sorry for him. You don't let him see it, but if there's anything you can do – sometimes I think I overreact. I'm like, 'What can I do for you? What you need? Coffee?' But you want to make them feel as much

love as possible. There's so many people that are like standing a distance away from him.

Potential Barriers

Figure 22 below depicts the overarching framework for this study, highlighting the potential barriers, as identified by research participants, that could block or inhibit individuals from engaging in AIDS dialogue or complying with AIDS prevention advice.
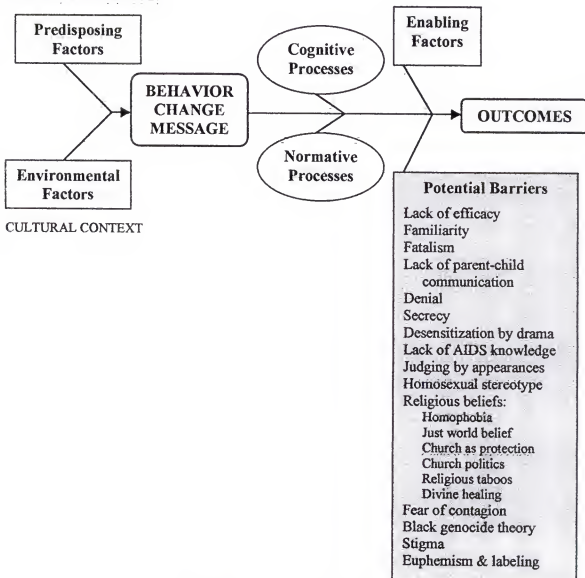

FIGURE 22: Barriers to an Individual's Compliance with AIDS Prevention Advice

Lack of self-efficacy

Although a basic component of a church-based abstinence message is to wait until marriage to become sexually active, many focus group participants questioned the efficacy of marriage in preventing HIV infection. "But it doesn't stop it," one woman argued.

A lack of confidence in safer sex practices also can be a barrier to effective AIDS prevention. One boy in the pilot group remarked that "there ain't no protection from AIDS from condoms."

A female pastor said many African American residents of low-income housing facilities have a substance abuse problem, and many also are sexually promiscuous. Hopelessness may be a major barrier to overcoming these addictions or changing risky behaviors. She commented

> They feel bad about it. They feel guilty, you know, in some sense. But, they feel like they've been doing it for so long, there's no hope and no one else cares, or whatever. Most of them want to get better, but they just don't know how. And so, that's where we try to come in.

Familiarity

Awareness is a prerequisite for learning and involvement. However, familiarity -- as the old cliché goes -- may breed contempt. The self-perception that a person has learned enough about AIDS can inhibit interest in future involvement in behavior change interventions.

A person's belief that he or she is already knowledgeable about AIDS can be a barrier to dissemination of new AIDS prevention material such as a *fotonovela*. One girl commented, "I don't have friends to give it to, 'cause most of my friends are pretty much aware of AIDS."

Another example of this phenomenon was shared by the woman who recruited many participants for the women's focus groups. She said:

> Trying to get women to come down here, most of them were like, 'Well, I've been to an AIDS class before, the AIDS training.' And so, if they go through once, they may not want to learn anything else. They don't take it serious.

Fatalism

A lack of response efficacy can ultimately lead to a sense of fatalism, since individuals may feel that nothing can effectively protect them from HIV infection. For others, a sense of fatalism seems to be rooted in their own fundamentalist religiosity. As one woman remarked:

> With these diseases springing up, there were 39 stripes and those stripes were for our demons. There must be 39 diseases. They keep getting worse and worse. They're not getting any better. You can talk to your people, and they'll say, 'All right. We won't do that.' And they do that. But there's no harm in keep talking.

The ultimate fatalism, the desire to die, may be pervasive within the social networks of some African American teens. Prevention advice would be expected to have little influence on a person in this state of mind. One boy explained:

> Some people, they suicidal, they don't care what they do. They'll go out and do anything just to kill themself. Like they in a hospital, and they don't know why they did it to themself.

The belief that AIDS might one day be cured may prevent hopelessness among many African Americans living in the current situation. One girl said she believes AIDS will be cured within the next five or ten years, definitely "by the time we have our kids." But another girl argued that "even if it was found, I mean, it would be very hard that everyday people could go and get some medicine."

Lack of parent-child communication

A barrier to effective parent-child communication is parents' lack of knowledge about AIDS or their resistance to learn about the disease. One woman remarked:

> A lot of young parents are very independent and were not taught for different reasons. Maybe they were rebellious, and that information wasn't passed on. So we have generational problems of communication.

A parent's lack of knowledge about child development can be another barrier to effective communication with youth. One woman commented:

> A lot of times it's just an awkward situation, or they don't know exactly what to tell them when they're 5, how much to tell them when they're 7. Some children are asking questions. Some are not asking questions. They're talking to their friends at the playground. If you're a parent, and in some cases nobody talked to you when you were a child, how are you going to talk to your child and educate them? Especially if nobody talked to you, then you don't know how to do it.

Another possible barrier to effective communication is a parent's misunderstandings about a child's sexual curiosity. When young children are involved in sexual experimentation, she said,

> That's just misguided curiosity. They didn't just wake up one day and just start doing something. They have reached out or tried to find out, and they can't. The parent has to be equipped to deal with that, even when they're 3 and 4 and 5 and talking about their pee-pee and their wee-wee.

When youth see their parents as too strict or old-fashioned, this perception may indicate a need for more open dialogue between the parent and child. For example, one woman related the story of her 13-year-old son who called her "old fashioned" because she would not let him go to the mall by himself. The boy reacted to the rule by comparing her to his father:

> He sat down and drew a column for his mom and a column for his dad, and he talked about the way we view life. Is my mother strict, or is she cool? He checked strict. He checked his dad cool. When it came down to decisions and

choices about things, he said his mom is old fashioned. His dad responds in a new way of thinking.

Barriers to *fotonovela* dialogue

Fear of rejection could be a barrier to interpersonal dissemination of the booklet. One boy did not expect all his friends to agree with his advice. He observed that "everybody's got different opinions."

During a two-week period, a total of 300 *fotonovelas* were distributed to African American teens. The boys shared 11 *fotonovelas*, girls shared 39, six women shared 150, and other female church members not in the focus groups distributed 100 *fotonovelas* to youths (Appendix D). Although rejection or lack of interest is a potential barrier to dialogue, most teens that actually shared the booklet said they were not afraid of risking a brush off. One woman who successfully shared the booklet with numerous teens and adults encountered others who "really didn't have time 'cause they had to go do things."

Another barrier to sharing the booklet, particularly among African American boys, could be a cultural norm of macho indifference. Although none of the boys indicated that sharing the *fotonovela* would be a problem, they also did not seem eager. When the boys were asked how they felt about sharing the booklet, their typical responses included: "It's fine with me," "It's fine to talk about preventing AIDS," and "It's good to talk about stuff to make sure they doin' OK." An example of this indifference was shown in one boy's remark: "It don't bother me. I can talk about most anything with them. But it don't make no difference."

This lack of eagerness to share the booklet also could have been rooted in the belief that their friends would probably react to them with indifference. It may be considered "uncool" for African American boys to give advice to one another. One boy

commented that "they so hard headed, they won't listen to it. They do the opposite of what you tell them."

One boy had a fatalistic attitude about sharing AIDS information with his friends. He commented that "you can talk about it, and the same day they'll go out and catch AIDS. You try to help them." Another boy, however, thought that using the *fotonovela* to talk about AIDS could make a difference. He commented that "if they read the book, they'll know how to protect themselves. If they don't read the book, they could go out and catch AIDS."

Most girls did not expect any difficulty in sharing the booklet, but a few expressed reservations. One girl commented that "it gonna be hard to talk about it," and another added that "it's not easy to come up to somebody and start talking about AIDS."

An actual barrier to effective dialogue about the booklet was the presence of adults and others. One girl remarked that "it's difficult when there's grown people around, and I thought when there's children outside or in the house." Similarly, when one boy was talking to his friends about the booklet while walking to school, his girlfriend was walking behind him. A couple of the boys laughed about this incident during the final focus group session.

Although talk is generally considered a beneficial activity, too much of it by one person can become a barrier to focused conversation. When asked if it was hard to talk about the booklet, one girl remarked, "Yeah, 'cause she was talking most of the time. I told her to stop talking, 'cause she talk too much."

One girl said she was a little worried about "whether they liked it. I was worried about the porn in the story, or something."

The topic that was most difficult to discuss, for one girl, was "the sex part." However, another girl disagreed, saying, "What's so bad about that, talking about sex? I talked about it."

Just world belief

A key informant from the Task Force said she became involved in the organization because she was disturbed that many African Americans in Gainesville believe that AIDS is a curse from God. Similarly, another key informant commented:

> AIDS is not retribution from God for people who have done something wrong. I mean, how do you explain an infected newborn baby, or someone who's gotten AIDS from a transfusion?

Ministers often talk about "innocent victims," commented Jean Tapscott, an administrator with the national Agency for HIV/AIDS. However, she argued that a theological rebuttal to that position is that "we're all sinners."

The belief that AIDS is divine judgment could be a barrier to perceived threat. Most African American churches need to prepare to minister to people living with AIDS, one key informant argued, because the number of church members affected by the disease will continue to increase. She said:

> As we get closer to the year 2000, we're going to see a lot more people coming back to church for very dire reasons. I think some people, after they get AIDS, might be more concerned about their eternal souls because they might believe they're going to meet their maker a lot sooner than they expected. Church is one place where people come sometimes hoping to get a miracle. If you think they're under punishment or a curse, you're not even going to bother to try to get them there.

One elderly woman suggested that the AIDS epidemic is a fulfillment of Biblical prophecy. She remarked:

> The Bible said such a long time ago, if people keep sinning and doing the same things over and over, there will be a disease that come over on this earth that they

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can't cure. And I hear in the news that they're giving them shots, but the shots don't take effect on them. So if people keep doing the things that God say don't do, it's going to be forever. It's not going to stop. It's going to go on and on and on until God get tired and wipe it off. Or they get saved. I hope they get saved. I really do. What's happening now has already happened, and it's been happening ever since the beginning. The crooked things will not be made straight until He calls for anybody who believes in the word of God.

Another woman said people must realize that AIDS is a fulfillment of Biblical prophesy so that they can avoid infection by living righteously in the eyes of God:

Actually this isn't new, because God already said in the Word that all these diseases would be let out. Some of them come from being rebellious, not obeying, and not trying to do things or live a good life or take care of your body and take care of things the way you should. It's very important that they realize that you cannot just live any kind of way.

The idea that original sin is the ultimate reason for the AIDS epidemic was found among the youth as well. When one girl commented that "if it wasn't for Adam and Eve, you wouldn't have to worry about that in the first place," another girl agreed, "Yeah, if it wasn't for Adam and Eve."

Several boys expressed judgmental beliefs also. After watching the "On the Pillow" video, a boy in the pilot group remarked that Terrence's HIV infection "served him right." However, another boy responded by arguing that "no one deserves to get AIDS."

One woman supported the idea that some AIDS victims are inherently "innocent" because of the way they were infected:

It's a lot of kids today who are getting blood transfusions, and they being tested with AIDS. They didn't go out and fornicate or nothing like that. Little kids is dying of AIDS, but they didn't do nothing wrong to get it. Some got blood transfusions, some got it from their mom.

However, another woman addressed this divine punishment belief, saying:

A lot of it is being ignorant and thinking it's just something that someone bad did. Some people think that God is punishing someone by giving them AIDS. I think that's why it's not dealt with very good, because they can kind of shun it off by saying, 'Well, you did something wrong, or you slept with the wrong person.' Not that it could be your wife that messed around and cheated on you.

The "judge not, lest ye be judged" belief prompted one woman to criticize the condemnatory attitude of many Christians:

We can't point fingers at nobody, because they always pointing back at you. We can't do people like that 'cause we're human beings. And God made us, and He loved us.

A woman living with AIDS, who lost a daughter and a companion to the disease, believes that Christians would not be so judgmental if they understood her loss:

Most people don't know what it's like to watch your 10-year-old die -- the pain and guilt. A lot of Christians who never deal with it, they never see it so they don't really care.

When a judgmental attitude toward people living with AIDS is widespread, it becomes a major barrier to AIDS-related outreach because it blocks compassion and perceived susceptibility. One woman argued:

The issue, to me, is what can we do to prevent it, not looking down on somebody else to say, 'Well, they shouldn't have did this, and that's why it happened.' I've gotten close enough to people that do have it, and them dying and suffering has nothing to do with the mistake that they made. And I think first of all, in order for us to be able to help people, we're going to be able to understand that it could happen to you as well as it happened to them.

Denial

A female pastor said that most African American churches in Gainesville are not responding to the local AIDS situation. She added that "out of all the churches, you have a few of them that are actually responding to it." A key informant commented that if people receive any information about AIDS in church, it is limited to "maybe a brochure

on the bulletin board or an announcement in church to please pray for such-and-such person with a long illness."

People who do not feel threatened by the AIDS epidemic often believe they are immune to the risk of infection. As one woman commented, "They feel like they are exempt. Most people feel like that it won't happen to them or anyone that they know." Some African Americans may believe that "if they just don't deal with it, it's just gonna go away," another woman observed.

Given that six women showed up for the first women's focus group, one participant suggested that more would have come if they had felt a need to be there:

> Even tonight, why a lot of the women didn't show up is because it's something that's not happening to them. That, 'It's not gonna happen to me.'

The denial among African American ministers was apparent when only six of 55 invited ministers actually attended a faith community AIDS awareness breakfast sponsored in February 1996 by the African American AIDS Task Force. Only one minister, a female pastor, explicitly indicated a desire to become more involved in AIDS ministry. In an in-depth interview with this pastor, she commented about her perceptions of apathy and fear among the other ministers who attended the breakfast:

> I really was blown away when I seen that none of them really wanted to do anything, because the question was asked, 'What can we do to help you to come and be able to educate people about this?' One of the ministers was someone I knew about. He was saying that when he preached his message that he said, 'Well, you better be careful who you're sleeping with' or something like that. It was a lot of ignorance.

Secrecy

Secrecy about sexual relations outside of marriage may increase the AIDS risk among many individuals Infidelity, including sex with prostitutes, is assumed to be a

secret but commonplace activity among many African American men. One woman commented:

> A lot of them are sneaking out just like everybody else, and they're picking up prostitutes. They're doing all these different things, and then they're going back home to their wife.

Even many African American ministers themselves may be having sex outside of marriage and trying to hide it from their congregations. One woman pointed out that

> A lot of the ministers are cheating, themselves, and they feel like, 'Well, you know, I'm picking one of the Christian women in the church, so this won't happen to me because she's only gonna sleep with me.'

One woman noted that African American ministers usually have little to say when a colleague is caught in adultery and added that "a lot of times, it's because they're doing it, and they want to keep it under wraps." Another woman argued that judgmental attitudes among ministers could be attributed to their own guilt and hypocrisy. She speculated that if a minister was infected with HIV, he would probably

> think it has to be that the person was a bad person, and they slept with someone else. So the way they play it off is just by throw it off and say, 'Well, you did something wrong, and so now you're punished for it.'

A distrust of the opposite sex was expressed by both boys and girls. Even though he might have been too young to be romantically interested in girls, one boy said he "don't even trust no girls." One girl said she does not respect those who sneak around and explained it this way:

> OK. Let me tell you. If you are sleeping around, why you ashamed about it? You doing it. So I mean, if you gonna be ashamed about it, don't do it.

Desensitization by drama

Some focus group participants suggested that when an AIDS prevention message is presented in a dramatic format, some audience members might dismiss both the script

and message as purely fiction or as a scenario that probably would never happen to them because "it's only a movie."

Even though all the boys agreed that the "On the Pillow" video was realistic, one commented that it was still only a drama: "It's real, but they're just acting."

One woman commented that "It depends on maturity, too, how mature that child or teenager is. They either take it as a warning sign, or ignore it. Most adults would do that, too. We say, 'Oh, it's just a movie.'" Another woman reacted to this comment, saying:

> It also depends who's with him. If the boys are with him, like right then they were all guys out together, he would feel like, 'Oh, man, all of them looking. I gotta take this shot.' You know what I'm sayin'? So I think it would be according if that child was alone looking at that video. You might get a different response.

Lack of AIDS knowledge

Lack of AIDS knowledge may have contributed to the church's silence on the issue. Several women said many African American ministers have avoided talking about AIDS from the pulpit because they lack basic knowledge and awareness of AIDS. Reflecting on the challenges of launching an AIDS ministry at Greater Mount Calvary Holy Church in Washington, DC, ministry director Kevin McDermott recalled that the first and most difficult obstacle was dispelling misinformation about AIDS. He commented that "education comes first. We deal with all the issues, and we don't shun any question."

In several different focus groups, a participant occasionally would ask the group a question that would reveal a lack of basic information about AIDS or sexuality. For example, when the girls were asked "What do you think when you hear the word

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'AIDS'?" the first response came from a girl who simply said, "I don't know what it is." When another girl was asked to discuss how concerned about AIDS she is, in her own life, she responded by asking basic questions about the disease: "What does it mean to be diagnosed with AIDS? What is HIV? What does HIV stand for?"

One girl who repeatedly asked these kinds of questions also may have been more likely than her peers to become sexually active. After the first session, the focus group moderator commented that this particular girl was "not no little miss churchy girl, not to me. I'm not saying she's not a virgin, but I can tell she hasn't done anything yet. She will."

In one conversation, several focus group participants helped two women resolve basic questions about human sexuality:

Woman 1: What is a homosexual?

Woman 2: A gay or a lesbian.

Woman 3: Men with men. Women with women.

Woman 1: What is a heterosexual?

Woman 2: That's a husband and wife.

Woman 3: Yeah, a husband and wife.

Woman 4: A man and a woman.

Woman 2: I always wondered why they call them heterosexuals. Like they go both ways.

Woman 4: No, no, no, no. Heterosexual goes one way. Bisexual goes two ways. Bisexuals are people that go with women as well as men. That's one way, too, that the disease comes in also. It spreads on to the wife or to the other lady that's in there. Because maybe they're having sex with another man or something and then the woman gets it.

One girl said "a lot of people" are not knowledgeable about AIDS, and others named their mothers, grandmother, brother, and a teacher as being ignorant about the disease. Another girl remarked:

> A lot of old people, they don't know what exactly it is. This guy had AIDS, and he like came and used the copier, and this teacher threw the copy in the garbage. Old people don't talk about it much. It wasn't big back then.

Although one woman had learned about AIDS transmission through training required for her teacher's certification, she had often heard others reveal their lack of awareness about how AIDS is spread:

> I've heard if you go to a restaurant and sit on a toilet, you get AIDS. Or if you shake somebody's hand, you might get it. But that's not true.

When asked the question, "Among your families and friends, can you think of anybody who is probably not at risk of getting AIDS?" most women said no one they know is free of this risk. One woman remarked that the only people not at risk are "the ones that are dead. That's about the only ones." The question did, however, reveal a couple of misconceptions about how AIDS is transmitted. For example, one woman said the unborn are not at risk, which they actually can be through perinatal HIV transmission. Another woman remarked that kids can get AIDS from "their dad, from that gene" -- indicating that she falsely thought the virus could be transmitted genetically.

Although most boys said that virgins, "little children," and babies are not at risk of getting AIDS, one boy challenged this misconception by explaining how perinatal transmission can occur. Another reacted to this idea with surprise, shouting, "Whoa!"

Many girls and boys considered a stranger to be the riskiest kind of partner or perhaps the only kind of partner that could carry the virus. Alluding to Terrence, one boy

in the pilot group commented that "it's like he shouldn't have slept with somebody he didn't know."

Judging by appearances

The idea that a person living with AIDS tends to look sickly may be a common misconception among many African Americans. One woman related:

> The other day, one of the smaller kids was crossing the street, and he yelled out to another group and said, 'He has AIDS.' Some of those children are walking with their peers and their teachers in different places in the community. They do see people, and they can kind of look at them and see that there's something different about them.

Despite this perception, one woman remarked that "you have to be careful if they fine, if they look good or they don't look good, 'cause you never know what type of disease a person have just by looking on the outer appearance." Another woman speculated that many people cannot tell when someone has AIDS because the infected person may seldom venture into public life when he or she is feeling ill. The woman commented:

> At school, I know we had a lady come in that had AIDS. And just looking at her, just like on the lady on the video, she looks well. There were times she had her down moments and she was going through the changes that go on with AIDS. And you don't see that part, 'cause she don't come out. But when she's back up and on her feet again, she looks like me and you.

Another woman remarked that "you look for a person to look all sickly, you know. And they're not." However, another woman in the same focus group did say that people living with AIDS can be spotted by their sickly appearance:

> If they're very thin, pale, weak looking, bones showing. But then again, they could look like a crack person.

Similarly, several girls believed they could identify an infected person just by appearance, particularly "if the person's sick," were "coughing up blood," or "had little

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scabs on his face" like the homosexual white man portrayed in the movie "Philadelphia."
Unlike the girls, however, all the boys agreed that it is impossible to determine whether
someone has AIDS by judging the person's appearance. One boy added that "the only
way you can really tell is if they tell you they have it."

Commenting about Crystal, the HIV-positive woman portrayed in the "On the

Pillow" video, one woman said:

> Most people have the idea that a person with AIDS don't look good. She was
> clean, and she was pretty, and she was dressed and everything. They have a false
> vision of what AIDS really are. Now, he didn't think nothing of it 'cause she was
> pretty and she was clean and dressed nice, and he would never thought she had
> AIDS.

Homosexual stereotype

Another common myth among African Americans is the stereotype that people

living with AIDS are usually white homosexual men. One woman said, "We've been

told it's some kind of disease for gays, homosexuals." Another woman commented:

> So many people think it's a homosexual thing. They don't know that more
> heterosexual people get it than homosexuals. And then some black people think
> it's more a white people's disease, when it's actually more African Americans.

Kevin McDermott, director of the HIV/AIDS Ministry of Greater Mount Calvary

Holy Church in Washington, DC, commented that most African Americans perceive

AIDS to be a gay disease because of their exposure to mass media. A female pastor

admitted that she once held this belief:

> At first, I thought it was a white homosexual disease because that's what I was
> told at first. But since I've been reading up on it, and talking to different people,
> that's when I found out that it is more of a black problem than among whites.
> One woman said this belief is common among many African American teens.

The belief could serve as a barrier to a person's motivation to learn about AIDS and

subsequently as a barrier to dialogue. The woman remarked:

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Most people do not know that it's not a gay thing. It's coming from all different kind of ways, and people are going to have to learn it so they can help spread the word.

However, one boy who seemed unfamiliar with this stereotype instead drew upon his own personal experiences to conclude that African Americans are the hardest hit by the disease. He remarked:

I know, you don't see white people with AIDS. When you see AIDS, it's black people. And the black people don't protect themselves.

Homophobia

A major component of AIDS stigma in the black church is the underlying association of homosexuality with the disease. A key informant observed that homosexuals are not accepted in black churches, and clergy generally do not even acknowledge homosexuality as a religious issue. She remarked:

Everybody is supposed to be heterosexual. Black churches don't embrace homosexuality. Most deal with it by saying we should forgive the person, and hopefully the person will reform. If they can't reform, they should just be celibate. You're not supposed to be having sex outside marriage, and you can't marry someone of the same sex, so therefore you'd better be unsexual.

Many African American churches view AIDS as "God's way of actually saying he was angry at homosexuals," a male pastor commented. "The church will probably have to rethink that."

A female pastor said she has personally known or heard of several African American women who have contracted HIV from a bisexual man:

A lot of the guys may be married and they're black, but they may be having sex with guys, too. You know, so it's like a mixture. And then they are going from one woman to another one, so it's like many of them got it that way, too.

She said bisexuality, like homosexuality, is not accepted in the black community. In many cases, homosexual African American men marry and join a church because they do not fit in elsewhere:

> A lot of men that I found out that are gay, they may be in church. They're in there because they really don't fit out there either. They just kind of live with it, and they're sneaky with it, and a lot of them get married but they're really bisexual. There's a lot of sleeping around. A lot of hiding things and being gay or whatever. It's sad – it's as hard for them to say that they're gay or that they have a problem with that as it is for someone to say 'I've got AIDS.'

A key informant from the Task Force said that if a man came to her church and announced that he was a homosexual, most people -- including her -- probably would openly reject him:

> They're like, 'You're not going to be openly gay here.' Hopefully, he wouldn't stand up and say that to the whole congregation, 'cause I could see the whole congregation making a bee line for the door. I wouldn't want a person like that to feel rejected. I'd try not to be one of those first ones out the door. I could see people saying, 'You mean I've got to hug this guy?' That's how people think. Something like that might be better said in private. Sometimes we bring ex-convicts to church, but we don't announce that they are from a halfway house because we don't want church members to start moving their purses. I'm sure some of those men are not heterosexual, but there's no way they could say or do anything openly gay in a black church.

Jean Tapscott, an administrator with the national Agency for HIV/AIDS, observed that individuals within many African American churches secretly engage in homosexual relations:

> The black church is very conservative, as a whole. The ironic part is that so many choir directors and choir members are themselves gay. Not every gay person acts typically gay. Their lifestyle may be hidden, but church members are dying whether they are straight or gay.

One male minister said his church does not condone homosexuality and denies that people are born with homosexual tendencies. However, his church is willing to minister to people who engage in homosexual behavior:

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That's a population that we know should benefit from what we have, and those are people we want to talk to also. God deals with the person that He has made, not the person that they have chosen to make themselves. Regardless of what people say, that 'I was born this way, or my genes were mixed up,' I don't believe that. A person goes out and through whatever they're going through, they develop this disease or sickness. That's what they were forced to do or wanted to do. I don't believe God looks at a little boy or girl and says 'You're going to be a good little homosexual when you grow up' and purposes for that kid to have to grow up and deal with how he or she's going to be treated and put down and have to live with all of that.

In most cases, homosexuals are not welcome in African American churches because most church members will reject and judge them. The minister said that if he were homosexual,

I wouldn't come to church either, if every time somebody saw me in the condition I was in, if I was a homosexual or lesbian or alcoholic, and they turned their backs on me. If they're sitting on a platform, if they're going to snub their nose at you, they look down on you before they give you a chance to say 'the reason I'm doing this is because I was forced into doing this. I didn't want to do it. I don't know how to break free of it.' We may judge, but situations might be different for different people. You have to be very careful how you look at folks and how you sum them up. Judge not. We all have things in our own lives that are not all right, that we have to deal with.

Although some members of his congregation might be homophobic or afraid to be near someone with AIDS, the minister said that

It would be good if there was a person who had the disease, who was homosexual, that came to share something that was sensitive. They would not come for you to put them down but to understand.

Even though the minister might welcome a homosexual speaker, he said many church members might react with fear and gossiping:

It would be unusual, because it's not something they see every day. They may be afraid. There may be some talk, because that may be something they're not accustomed to. Or maybe they have family members with that lifestyle. I wouldn't doubt it.

In addition to being confronted with stigma, any person claiming to be a homosexual might not be accepted in this church unless he or she expressed a willingness to become heterosexual. The minister remarked:

> If a person came to church like that, you have to wonder if they're coming for change. Are they coming to remain as they are? What is our purpose when we go to church – are we going to improve our understanding? If a person is mean and hateful, should they come to have that addressed, or is it all right for that person to be mean and hateful? Because that's just as bad as being homosexual. It's wrong. What is your motive for coming to church?

An incident at a church banquet revealed this latent stigmatization of homosexuals among many members. The minister said several groups performed skits as part of a "Night at the Improv" presentation. One drama group included a girl from the church, and several actors were preparing their costumes and props when the banquet guests began to arrive:

> When we walked in, there was this guy dressed up like a woman. OK, I mean, everything – makeup, wig, dress, fur, feathers, everything. Right away, everybody started more or less moving to the side and whispering, 'What's that?' It was so funny. I was saying, 'Oh my God, what's going on here?' You want to remain open. I went over to speak to the person, and they didn't really pay me any mind. But at the end, it was all part of the play. He remained isolated and to himself because that was his role at the time. He didn't want to give away what he really was. But he allowed the people to whisper and pass judgment about this homosexual or whatever, and that's when I saw it.

Church as protection

Individuals with a social-extrinsic religiosity orientation tend to consider church the place to form social relationships. Several women in the focus groups commented that single women are often lulled into feeling safe from the risk of getting AIDS if they are involved in a church and date men within the church. One woman commented:

> I've heard people get AIDS that married different men that were in the church. They didn't go and say, 'OK, will you take an AIDS test?' They figure he's in the church, he's nice, he treats you good, he opens the door for you. He wants to

marry you or whatever, OK, fine. You may be a little slower at going ahead and maybe going to bed with him because you may have set those kinds of standards because you're a woman in church and all. But do you know how many young women that do get lured by men who are in the church?

In response to her comment, a woman offered this warning:

Another thing that you can't forget -- when you come to Jesus, you still have a life before that. You don't know what that person did before they met you. So I don't care who it is. I don't care how they look. While they are in the church, they still had a life before they came.

Another reason that church-going men may not be "safe" is that many who become involved in religious activities are not necessarily there for purely spiritual reasons. One woman argued that "a lot of times, men come to church just to look for women. And by the time they get them and hook up, boom – it's like, 'I didn't know.'"

In her own experience of placing blind trust in a Christian man, one woman assumed that he was "safe" because he was involved in church and then allowed herself to fall in love with him:

I wasn't worried about it 'cause he was volunteering and stuff. Myself, I knew about AIDS. But then when I met him, it's like, I mean, who can walk up in somebody's yard with bulldogs and Rotweilers not on a chain, and don't get bit? So I felt like it was the Lord sent me to this person. I didn't jump into bed with him. It was a whole year before we decided. We didn't do no test, but after we did it, I went and got a test. I know it's my mistake. But when you're in it, you got a conscience.

Social-extrinsic religiosity is not a protective factor for youth, either. Even if youth hear abstinence advice at church, they do not necessarily heed the advice. A boy in the pilot group commented that "if they want to go out and have sex with somebody, they gonna go out and have it, if they ain't married."

Church politics

Many African American ministers "don't want to talk about the bad stuff," as one woman commented, because they fear alienating or offending their congregations. She said:

> Most people don't even want to hear about it. Some ministers don't even talk about sin 'cause they want their people to stay there. A lot of them don't deal with anything that some congregations don't want to hear.

The risk of offending church members is a great concern among ministers for political reasons, in addition to the perception that when people become offended they ignore or disregard the message itself. One woman remarked:

> You go too far in dealing with it, some people get offended. Instead of them seeing the point of what your saying, because it's not dealing right with them, they get offended and they want to know, 'Why are you bringing this up? Why do we need to go into it that much, 'cause I don't have to worry about that.'

Among most African American churches, even in large metropolitan areas like Washington, DC, "AIDS is terribly politicized," said Jean Tapscott, an administrator with the national Agency for HIV/AIDS.

Religious taboos

Some ministers may avoid preaching about AIDS if they do not see the disease literally addressed in Scripture. In some fundamentalist churches, a non-literal interpretation of the Bible is considered an act of heresy. One woman speculated, "Maybe that AIDS is not in the Bible – they don't see it in black and white, and therefore they don't preach on it."

Sexuality is often considered a taboo topic for Sunday morning sermons. When the topic is addressed, it is often presented as abstinence advice. The incidence of

pregnancies among church-going youth, however, shows that this advice does not always promote lasting behavior change. One woman remarked:

> We've counseled with a lot of young people that are in the church that have heard the pastor preach about not letting men use you and have sex with them outside of marriage. And if they want you, you need to let them marry you. And still yet, we have several of them getting pregnant. Yes, they're being educated, but what else can we do to actually make it stick?

The abstinence message promoted by many clergy is not open for debate in most churches. One woman commented that "the problem is that a lot of ministers are not receptive to receiving the pros and cons." Recalling how the preacher's sermons addressed sexual issues in her own church, one woman observed that "the minister's saying, 'No sex. Don't have sex.' But they wasn't talking about protection. They wasn't talking about it from both sides." Another woman argued that teens are not willing to admit they are having sex because "the church has not come to grips" with the AIDS epidemic.

Many ministers do not provide information about STDs or pregnancy prevention in church because they assume the youth will not have sexual intercourse before marriage, a key informant said. She observed that while most ministers do not condone birth control from the pulpit, some nevertheless arrange birth control for their own children:

> All of these children are going to be angels. Over their dead bodies they're going to be angels. We don't accept that our children are going to become sexually active, and we don't prepare them with any kind of birth control. My daughter is preteen now, so what am I going to do? Take her to a gynecologist and get her on birth control pills? That's like saying, 'I realize you're going to have sex now, so I'm trying to keep you from getting pregnant.' Preachers do that with their own daughters.

Many African American churches are reluctant to discuss AIDS issues because they tacitly assume that no church member will ever have sexual intercourse outside of marriage, one key informant said. She commented:

> Some churches might be less open to discussing AIDS because everybody is supposed to be abstinent. We know (laugh) -- we know that is a problem.

Another reason preachers may consider the issue of promiscuity irrelevant is that most church pews are filled with senior citizens. One key informant commented:

> We have mostly older congregations, which is a reason why AIDS doesn't come up in church. When most of your members are in their 50s and 60s, there's probably not a lot of sexual activity, illicit or otherwise, going on. That's what they (the clergy) are hoping, at least. They spend most of their time visiting the sick and conducting funerals, and those funerals are not for people with AIDS, they are for other things. The people who might see more AIDS cases are at the funeral homes.

Another reason ministers may avoid addressing controversial AIDS issues is that they may perceive that AIDS information is already abundant and available to everyone who wants it. One woman described a scene from a movie to illustrate the consequences that can happen if ministers refuse to become involved in AIDS education:

> In this movie I saw, in the last scene, there was a minister. He was like preaching like he would do a Sunday morning service, and there was nobody in there. And he was one of the ones that was raptured. Then his kids came in, and they said to him, 'Why didn't you tell us?' And his response to them was, 'It was in the Bible. You could have read it, too.' So in other words, there are a lot of things that the ministers will not take time to focus on. So what they're saying is, 'There's literature. There's this, there's that. You could have gotten it.'

Some ministers may believe they are simply not "called" to deal with AIDS in their own church, and to do so at the request of someone outside the church might be considered an act of disobedience to God's will. The belief that Christians have a variety of divine "callings," according to their individual spiritual gifts, implies that only certain ministers are called by God to initiate an AIDS ministry, while the others do not have this

duty. One woman explained that "there are different kinds of ministries, in different areas. Some are for restoration, some for healing, others for going out and evangelizing."

Most African Americans are not likely to talk about AIDS or their own risky behaviors in church settings, one woman argued, unless a minister or other leader is open and willing to discuss the entire range of problems that individuals might encounter, including such taboos as adultery, drug use, and incest. Similarly, ministers increasingly gain awareness and knowledge about issues by facilitating these interactions. In her own experience as a counselor, this woman observed that:

> If you counsel a lot of people, and you really are there to help with whatever, then you really see the real world. But if you just deal with certain things, you're kind of like off limits to certain things. Then people aren't gonna come and talk to you about it. You're not gonna really know as much. That's what I think has happened to a lot of the ministers. So, unless you get out there with a lot of people and get into the helps ministry -- the ministry that helps everybody, no matter who they are -- then the more you see, the more you want to know so you can really help them. A lot of them just don't care about that.

Moralizing may be a typical characteristic of many church-based prevention messages of all types. One girl said that if her church created a drug prevention video, "they would probably tell that it's wrong to do drugs, and you can die from HIV and drugs." Another girl added that "they would tell them to stay away from drugs."

Expectation for divine healing

Sickness is a taboo subject in many religious contexts, because a true Christian is believed to be able to receive physical healing from God if they are not living in sin. Conversely, sickness is often viewed as the result of sin or demonic bondage. Even if ministers did talk openly about AIDS, one woman argued, they would probably tell an infected person to "just have faith" for divine healing, rather than deal with the person's

daily emotional and physical needs. This is how many African American ministers deal with people who have other diseases, she remarked, adding that

> It's not just AIDS, either. AIDS more so. But it's sickness, period. Because the easy way to get rid of sickness is to say, 'Have faith.' Then you get healed, and that's it. And then when you don't get healed, and you don't get any better, it's like you don't have any faith.

Another woman added that faith healing removes a minister's responsibility to help in other ways: "It takes it off of them. So that's the easy way for them to run away from it."

Despite this criticism of divine healing of AIDS, many women appeared to strongly believe in it. Several told stories about how people they knew had been healed. For example, one woman recounted this story about a 40-year-old man infected with HIV from a blood transfusion:

> He said, 'Well, I can 'fess it up to the neighborhood. So if there's anything out there you want to know, you can ask me.' He was saved, and now he don't have it. I look at him and see that it's a blessing. When he went to have his last blood drawn, they were asking him what happened. He said he got Jesus.

After she shared this anecdote, all the women clapped, and one exclaimed, "That makes me shout!" Although one woman often prayed for the divine healing of her brother, who died of AIDS, she believed the salvation of his soul was a prerequisite for his physical healing:

> My opinion toward my brother was I always went in there with this feeling that we all gotta go. Are you ready to go? If something happened right now, do you have Jesus Christ as your Lord and Savior? If they said they didn't, I pray, and I don't even think the illness is still there. To me, you can be cleansed if you want to. They don't have it, so they got to receive it. So you can't say that to them when they don't have it.

A barrier to AIDS ministry in many churches, one woman argued, is that many ministers do not believe that "God will heal all diseases." A female minister said in a

long interview that a belief in divine healing is not a problem when people living with

AIDS see it as "something to hope for, so they will want to live."

Fear of contagion

One woman related a Gainesville incident that highlighted the widespread fear of

HIV contagion in the community:

> This man went back to his hometown, and he had AIDS. That's where he was going back to die. So he went to the swimming pool, and somehow, everybody had found out that he had AIDS. He got in the swimming pool, and everybody got out. So they thought they could get it through them being in the same water with him.

One of the boys recounted the same story and said that he was actually in the pool

when it happened:

> We went swimming, and they said this man swimming in the water had AIDS. I saw it. I wasn't too worried about it, but all these other swimmers were scared and everything. They were idiots 'cause there's chlorine. I was laughing.

Most of the other boys in the pilot group said they did not know anyone

personally who has AIDS. One woman said she knew she could not contract the virus

through casual contact, but admitted an incident involving her child's HIV-positive uncle

that revealed the fear and ignorance she once had:

> We was on the city bus together, and that medication AZT fell out of his pocket. And I'm like, 'Hey, you dropped this.' And I looked at it. He said, 'Oh. Yeah. I got AIDS.' I was speechless, you know, 'cause he didn't look like it. And then he told who the person was, and I'm like, 'Oh, my God.' You know, 'cause he had been over at my house, sitting on my couch. I went home, and I got some bleach, and I just wiped my seat. Then after I did that, I felt much better about that. But then, I made an appointment for me. You know, I'd never had no intercourse or nothing like that. But I made an appointment for my kid to go get tested because I didn't know if it had ran in the family or not. You know, it kind of was a shock. I mean, he was fine, smooth, sexy, good looking. And when he tell me that, I'm like, I couldn't say nothing. I was speechless all the way to my bus stop. I almost passed my stop.

A woman recalled her own fear of contagion the first time she went to visit an HIV-positive relative in the hospital and remembered how education eradicated that fear:

> When I first went to Alachua General to see my cousin, I was very scared. I did not want to touch her. But after I went and a lady talked to me, I was like holding her hand and everything. That fear disappeared.

One woman living with AIDS said she has more reason to fear contagion of viral infections from others because she is immunosuppressed:

> I ain't gonna go bite nobody or nothin' like that. If anything, I should be scared of them, 'cause they the ones that can kill me.

Public fear has forced many people living with AIDS into total isolation. One woman remarked that "most people who have AIDS, they die lonely because so many people are scared."

A male pastor said his first contact with people living with AIDS occurred in 1986 when he was working as a psychiatric technician in Sarasota, Fla. He said the hospital began instituting new HIV precautions, including the "red bagging" of all items touched by an AIDS patient. During his rounds, he met a white man with AIDS who stayed in the substance abuse wing. He commented that the young man

> was a real nice guy. Very easily, you could see how people could just say 'uh-uh, I'm not going to touch him.' He needed somebody to reach out to him. He had a girlfriend who was a corporate executive at one of the big department stores, and she was trying to make a separation from him. You could see how bad folk treat people that have AIDS. I could have distanced myself.

Black genocide theory

Black genocide theory posits that the AIDS epidemic among African Americans is the result of a malicious and deliberate scheme by whites to remove blacks from American society. It assumes that blacks were inoculated with a precursor to HIV during the 1950s as part of polio vaccine experiments. This assumption is related to outrage

about the Tuskegee experiments in which incarcerated African American men were deliberately infected with syphilis.

One key informant said she is a proponent of black genocide theory. She has presented lectures about genocide theory to various organizations in Gainesville. The woman explained that her belief in this theory is based on a lack of proof for competing theories:

> I know a lot of preachers might be getting their information from the CDC, which probably is covering up what I'm thinking is happening. They're presenting it from the standpoint that somebody had an affair with a green monkey over in Africa, because that's what Africans do, after all. I think this is part of a stereotype, and that's why it's been beaten into a whole bunch of people's heads to make them accept it. I can't believe they can get away with that hypothesis of how AIDS got started. There's no proof for it. People say there's no proof for the genocide theory, but there's no proof for the green monkey theory, either. If people knew the truth, it might reduce some of the stigma.

None of the focus group participants overtly cited black genocide as an explanation for the origin of HIV. When asked where AIDS comes from, several women indicated that they had learned about the origin of AIDS from their children. As one woman commented:

> The kids told me that in some country they had a monkey. He had a pink tongue or something like that, and he bit a man. That's what they said. And then, it got carried back and that's how it got started.

A boy in the pilot group said the disease came from a green monkey, while another said AIDS came from "people doin' it with a dog."

None of the women claimed to know where AIDS came from. One suggested that AIDS, like other diseases, is the product of sin. "With all this sinning," she said, "one gonna be worse than the next." Another woman described the various theories she has heard:

I heard that it was done in a test tube in a laboratory, and it was experimental. I heard that some guy created it by mixing things together. Another one was the story from Africa about people eating monkey brains and all this stuff. From the rain forest, hanging out in there, that maybe something got on them and they came out and brung it here. I think nobody really knows how it got started. Some people say it was done through gay people, homosexuals.

In response, another woman said she thinks the "test tube" theory has the most

credibility, while the "monkey meat" theory is the least credible:

I think it started in a laboratory somewhere. All this monkey business. People in Africa, just like people in the United States, have been eating domestic things for years.

Stigma

A female pastor said that secrecy among people living with AIDS often is rooted

in embarrassment and fear of dying. Thinking about how she might react, the pastor

remarked:

I've even myself said OK, if I took the AIDS test and I found out about it would I say that I had it? Of course, it's a question I couldn't answer. So I can imagine how they would probably feel and why they wouldn't say anything.

When the boys were asked how they might react if a friend admitted to being HIV

positive, one boy merely said, "I'd give him up as a friend." Another said he would

avoid the friend only "if he had a cut on his hand," but added that the only time the friend

would really be incapable of spreading the disease would be after death: "When he's

dead, he can't give it to you." In another conversation, a boy in the pilot group said, "I'd

start backing up," and then another boy reacted by saying:

No, no, no, no. I'm not gonna do that to you. I know that AIDS can't be transferred that way. I know if I don't have contact with you, have sex or nothing like that, it's OK. Just don't spit on me, sweat on me, or beat me up.

Most boys did not demonstrate a sense of empathy toward people with AIDS. If a

friend disclosed that he or she had HIV, one boy in the pilot group said he would not

keep the news in confidence: "I wouldn't want to go messin' around with them. And I'll go tell the whole world that person got it, so that way, nobody else gets it." When asked what they would first say to a friend with AIDS, several boys in the pilot group said they would probably interrogate the friend by asking questions such as "How did you get it?" "From who?" "Who, what, where, when, and why?"

Despite the perceived social distance that seemed to underlie discussions about AIDS patients among many boys, one boy recognized that stigma is a barrier to AIDS prevention and that assigning blame does not teach people to avoid making the same mistakes. He commented:

> People should stop laughing at the person who's got AIDS and ask them how they got it. A girl lie to him and just make him do it, and then he catch it.

Among the girls, only one claimed to know anyone with AIDS, and the person was her uncle. She remarked that "at first, I felt sorry for this person. They can't do anything about it."

All the girls indicated that they would show compassion and not judge or expose a friend who had AIDS. One remarked, "I'd tell her that no matter what, I'd be there through thick and thin." Another added, "I would cry at first 'cause it's my best friend. I wouldn't say they need to face reality. I wouldn't say they should have kept abstinent."

Most people living with AIDS hide their diagnosis from others out of fear of rejection, one woman speculated. She observed:

> They're embarrassed, and they're trying to protect their families. They know how they may get criticized or whatever if they come forward and how people will begin to reject them. So many people are so scared of it. The Christian people are the ones that want to find out, but they don't want to hug them. They don't want to shake their hand. They don't want to go to church with them.

In many cases, if a person living with AIDS went public in church, someone would probably "do something to get rid of that person from their church because the majority of people don't want them there," a female pastor commented. She added that most "church people are just like 'Well, I'm scared, you know, that's catchy.'"

Many people living with AIDS do not disclose their illness to others because they fear losing their job or being prevented from obtaining future employment. For example, a key informant said she knows an HIV-positive, African American woman who cannot explain to her employer why she must miss days from work.

A lack of knowledge about AIDS also can lead to stigmatization of people living with the disease. A key informant explained that most church members need to learn more about HIV transmission before they can begin interacting with people living with AIDS:

> You don't want people to act like they can't sit in the same pew with someone with AIDS because they think if they sit too close they might catch it themselves. That's where education might need to come in. AIDS is not an airborne disease, but some people treat it as if it is. They're afraid to have you come to a dinner, because they don't want to have to wash the dishes afterwards, or something crazy like that. People should be more concerned about a person with a compromised immune system catching something from them, with people going around coughing all the time, than worrying about catching AIDS.

A key informant said that African Americans are just as unsupportive of people living with AIDS as white people are:

> You cannot just say it's a problem of the Caucasians. We are very much affected by it, and have been in denial. We are depriving our families of the care and love they need.

A couple of women speculated about the stigma and fear reactions that would likely occur if a local African American church hosted a prayer service for people living with AIDS.

Woman 1: I would love to have a service just for people that have AIDS. But people don't know about what someone's sickness is. And it's sad, but once they find out, a lot of times people don't want anything else to do with that person. So if you do it in a regular service, even though your heart is out for that person, you cannot allow everyone to know that about them because people will freeze up and turn from them.

Woman 2: I doubt if many people with AIDS would actually come because they'd be so afraid that they would know who have it. You would point them out, and that's really not what the service would be all about.

A common response to this fear may be to simply ignore a person living with AIDS, even when that person's illness presents evidence that the disease is spreading through the community. Although most women said they would accept and assist a person living with AIDS, they assumed that most other African Americans would reject the person. As one woman speculated, "If there's somebody around that have it, they probably don't deal with them. It's just like they shut them out."

Another woman observed that many African Americans in Gainesville have refused to become involved in AIDS prevention efforts, even when they can see that some of their own people are suffering. She included herself in this silent majority:

We see them catching AIDS over and over and over. But what do we do? Nothing. Nothing.

A likely explanation for this inaction is the fear of stigma itself. Often when individuals do attempt to help a person living with AIDS, they must share the burden of stigma. One woman observed that

People sometimes shun the whole family when one person has AIDS, 'cause they think if you're taking care of that one person, you have it, too.

Another fear response may be condemnation: "You know, the sad thing about it is we do point fingers, and we do still have that fear," one woman reflected. Others may

avoid contact with people living with AIDS, as one woman suggested, "because they

don't want to deal with pain."

Lack of confidentiality among clergy can inhibit people living with AIDS from

seeking assistance from the church. In assessing the social environment in her own

church, a key informant commented:

> People in church might not commit some of those major sins like murder, they
> just gossip. If a person with AIDS talked to a minister, he would be expected to
> keep it confidential. I have heard horror stories from people of how they'd told a
> preacher, and the next thing you know, it was all around the church. They were
> afraid the person was going to somehow spread AIDS. Preachers need to learn
> how to keep things confidential, and they need to be educated about what poses
> danger and what does not. Then they'll know how to treat somebody who might
> come in.

Euphemism and labeling

AIDS communication scholars have argued that the word "AIDS" does not

merely label an illness caused by a virus (i.e., Treichler, 1988; Sontag, 1989). Treichler

(1988) argues that the name

> Constructs the illness and helps us make sense of it. We cannot, therefore, look
> through discourse to determine what AIDS 'really' is. Rather, we must explore
> the place where such determinations occur: in discourse itself, which is inevitably
> marked by our struggles to represent what we *think* AIDS really is and to
> conceptualize what it *really* means... Our names and representations can
> influence our cultural relationship to the disease and, indeed, its present and future
> course... Making sense of AIDS compels us to address questions of signification
> and representation (p. 195).

In the present study, focus group participants were asked to say what came to

mind when they heard the word "AIDS." Participants in the first women's focus group

offered a variety of associations, including: death, suffering, burdens, medical bills, pain,

change, change in your family lifestyle, fear, and "a lot of loss." In response to the same

question, a girl commented that "I see somebody that did something wrong, and they

regret what they did." None of the teens, however, mentioned sickness, suffering, or death as concepts associated with AIDS.

A major cause of stigma is the tendency of some Christians to equate a person with sin. As one woman commented:

> Just think, you could get raped or get a blood transfusion, and you could end up with AIDS. You have to get people educated enough to know that, OK, however she got it doesn't make a difference. Because the thing is, once you sin and you ask God to forgive you, it's no more. You've got to get past the people that still want to hold the past up.

Equating people living with AIDS with the disease itself can be considered a way of dehumanizing them. One woman commented that "AIDS comes in all forms, shapes, sizes." And in response, another woman reinforced this "outsiders" view, saying, "That's a good point. What do they look like?"

One of the few reasons a minister might feel obligated to deal with AIDS in church would be if one of the members died from the disease. But since most people living with AIDS are cloaked in stigma or total secrecy, particularly in church settings, this situation rarely arises. One woman speculated what might happen if a minister were in this situation:

> What's amazing is when ministers preach funerals over AIDS patients. And yet, they don't know that much about it or they don't get involved. But they stand there, quoting from the Bible.

Although this situation might be more commonly found in smaller cities such as Gainesville, one key informant reported a similar incident that happened in Detroit. She said a pastor conducted a funeral for a person with AIDS without mentioning the disease:

> The minister simply said that the person had died from a disease that affects a lot of younger men, so that the deceased family members would not be embarrassed.

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An example of church stigma

A subtle example of the stigma surrounding AIDS in Gainesville's African American community was seen when Allen Bunch, an African American who lived with AIDS and had long served as an advocate for AIDS issues, died on June 8, 1997.

An obituary for Allen never appeared in the *Gainesville Sun*, and his memorial service was never publicized. Several people commented that he probably had been cremated by a funeral home in another county, although they never volunteered possible reasons for this. Allen lived with AIDS for nearly 15 years before he died at age 47. He served for many years as a public speaker, giving his personal testimony about living with AIDS for schools, prisons, churches, and various community organizations. In addition, he was co-founder of the African American AIDS Task Force, launched in 1994.

The site of Allen's memorial service was a small wooden church in downtown Gainesville. It is located on the outskirts of an area known to the African American community as "Porters Quarters," a low-income, red light district where many black prostitutes and drug dealers are widely reported to hang out late at night. The building is identified as a church only by a small white sign on the front, about three feet across, with the church name painted on it in black hand lettering.

Two female ushers in the back of the sanctuary handed a paper fan to each person who entered. The fan was a piece of white cardboard stapled to a wooden stick. On the front of the fan was a black and white photo of the pastor's family, titled "Terrific Together." On the back was the address, pastor's name, and church motto: *"We are reaching out, not out of reach."* The sanctuary was dimly lit, with white plaster walls,

red carpet, and two rows of wooden pews separated by a center aisle. There was no casket, flowers, nor other decorations for the funeral – just the church furniture: the pulpit, a communion table in front of it, a choir loft on the far right wall, and a synthesizer next to the far left wall.

About 30 people were present, including six members of the deceased man's family, who sat in the front pew. After a solo and hymn singing, the pastor invited anyone who wished to come forward and offer "words of comfort" to Allen's family. Six people spoke – a mentally challenged, middle-aged white man who lived in Allen's apartment complex, an elderly African American woman who said Allen often took her to church, a pregnant teenager who was too emotional to speak, two middle-aged white women who assisted Allen as social workers, and an African American woman who helped Allen found a support group for African Americans living with AIDS. This last woman was the only person to utter the word "AIDS" during the service. Everyone else, including the pastor, referred to the cause of death as "a long illness" or "his illness" or "the disease." The pastor's message focused on seeking joy when a Christian goes to heaven.

The program for Allen's memorial service contained the well-known poem "Footprints," as well as a brief obituary written by someone in the church. This obituary commented that when Allen "was stricken with HIV, he decided to confront his illness with an open mind. He didn't want his condition to remain a secret. Therefore, through his concern for others he was inspired to become an advocate for AIDS so that he may share, warn and protect others of the perils of this disease."

A key informant attended the memorial service and afterwards commented that the poor attendance and euphemistic rhetoric indicated widespread stigma within the local black community:

> Really, a concerted effort to be in full unity behind that person – it appears that it's not there. With this death of Allen and the memorial service that followed, it really appears that – I really believe very strongly that we don't have that support and backing. We still have that fear, that stigmatism.

One woman's secret tragedy

A female pastor related the story of a 37-year-old African American woman living with AIDS who discovered she was infected in 1992 when her 7-year-old daughter tested HIV positive. The woman with AIDS recalled that her daughter had been sick since birth, with recurring fevers and ear infections, and previous medical tests had been inconclusive. After the girl was finally diagnosed with pneumonia, a doctor suggested an HIV test. By this time, the girl already had full-blown AIDS. Health care workers waited a month before recommending an HIV test for the mother. The girl survived three years beyond her diagnosis. The woman described her initial reaction when she first learned that her daughter had AIDS:

> I started to go back in that room and disconnect everything from her right then, not letting them do nothing. I didn't think she was going to live as long as she did. I went through this time when every time I woke up, I thought I would find her dead.

She said her daughter was hospitalized in isolation, and many nurses were not responsive to her needs:

> They had all her food lined up on the outside of that glass. They wouldn't change her bed, or come in when she called.

The girl took AZT and 14 prescriptions, along with injections and an intravenous drip, the mother explained. Although the girl grew weary of countless pills, shots, and

other treatments, she cried only once when a nurse accidentally inserted a hypodermic needle incorrectly. One night, the girl complained that she was too tired to do an asthma treatment before bed and begged her mother to do it in the morning instead. The next day, the girl had to be taken to the hospital:

> She didn't come back out. A lot of times, I think maybe I should have made her get on that asthma thing. It was just her time to go. I tried to tell her she had AIDS, but she didn't believe me. In a way, I was glad she didn't believe it. People were pushing me to tell her, and I said, 'No, that's not a good idea to tell her.'

The woman was infected by her boyfriend of 10 years, and he died shortly before the daughter died. However, the woman never learned how he had received the virus. She remarked, "I never really got the chance to sit down and talk to him about it. He died without even telling me." She said the man could have contracted the virus while serving a prison sentence. In evaluating herself, the woman said she did not fit the profile of a typical person at risk of HIV infection:

> I don't even know what it is to be drunk. I'm no drug addict, and I can count the men on one hand. You can believe that 'cause my momma was strict. That's why I was so shocked when I found out.

She suspects that he had known about his own infection for many years:

> When I found out I was HIV positive, he was sick also. When I sit down now, I can think about things he would come into the house and say. One day, he came in and said, 'There's something I have to tell you, one day you ought to know.' He would say stuff like that, and whew, over my head. He was a big stocky man, and he would eat up everything in the house. But later, he looked like he was on a diet. And sometimes he would be looking up at me and say, 'You know, you look like you getting knots on the side of your neck,' you know, the lymph nodes, and I was like, 'What are you talking about?' That's what he was looking for, 'cause he already knew some of the symptoms. That makes me think he knew he was sick but he never told me. I could have killed him. I can laugh about it now, but before I could never understand it.

When she started walking with a limp in 1987, medical specialists diagnosed her with multiple sclerosis. Five years later, after testing positive for HIV, she learned that the muscular problem was an AIDS-related disorder called HTLV. She still walks with a brace on her leg, an obvious handicap that often requires an explanation:

> When you have HIV, it makes you lie. It's one lie after another. 'Cause somebody will ask me, 'Ooh, what's wrong with your leg?' 'Oh, accident.'

Although she has been celibate since the HIV test, the woman said she is still faced with sexual dilemmas. She realizes she could have casual sex without informing her partners about her HIV status but said she "couldn't do that." About a year before her diagnosis, she married a former drug user who has been imprisoned during her illness. Although her parents and siblings are aware of her diagnosis, she has not disclosed her HIV status to her husband's family, despite the fact that her brother-in-law recently tested HIV positive. She believes her husband is not infected, but he insists on having unprotected intercourse with her when he is released from prison:

> I'm having a hard time with him. I can't believe that he hasn't put me down or had a negative attitude or anything like that. Now that he's coming home from prison, I don't know how I'm going to be able to handle him, 'cause I'm having to fight him off of me. When I say, 'We can't be like we used to,' he'll say stuff like, 'Oh, we can die together.' I wouldn't wish that on nobody.

She said living with AIDS often has left her "feeling like an alien, like I didn't need to be here. I'd walk into a room full of people, like going into church every Sunday. I felt so different from everybody else." She said she sometimes considered suicide:

> I had all these voices saying 'Why are you sitting around waiting to get sick?' I didn't care about taking medicine, 'cause I was going to die anyway. I was really messed up on the inside.

Although she did not disclose her illness to others, she internalized the stigma and became increasingly angry:

I got to where I hated people. If people come and knocked on my door, I would not let them in. I was terrible.

The woman said she feels "OK now" because her spiritual and physical strength are increasing and because her church is compassionate and supportive. In reflecting on her faith in God, she said:

I knew there had to be a better way to deal with it. You just have to put your trust where it's supposed to be, 'cause no man can make you feel any better. I have a man above.

The female pastor said she and her husband are supportive but are not trying to keep the woman's illness a secret within the congregation. The pastor suspects that one person may have overheard her talking to the woman about her illness, but no one has mentioned the issue to the co-pastors. The pastor does not discuss the woman's illness publicly because church members do not need to know about it to avoid physical endangerment and because some might not be emotionally prepared to cope with the news:

We know they are not actually in any kind of jeopardy of receiving it just by her sitting there by them in church. That's the only reason we would go into depth as far as telling them all of that. Some of them may not be mature enough to handle it. That's why we do it – we spare her the hurt. Even though she's sick, everybody loves her to death, and they're there to show her they love her. We don't want all of a sudden for them to be like, 'Don't touch me.'

The woman with AIDS said her spiritual strength has been fostered by support and compassion from the co-pastors and other members of her church:

If it wasn't for this church, I would still be in the cold. I would still be crying about it. They gave me the confidence that it was OK. I think most of them know, 'cause I get a lot of hugs now. I guess you have to get out and seek people who want to help.

The female pastor said she tries to offer comfort through prayer and Bible study:

In her life, she goes through ups and downs, ups and downs, but we pray for her all the time. We teach her a lot of the Word of God and build her faith. That's

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really been a help to her to come out of a lot of depression and all that she's been through.

After hearing her diagnosis, however, her first interaction with a pastor had been a painful experience. She and her sister were attending a different church at the time, and they went together to their pastor's office to seek counseling:

> We was sitting up in his conference room, and he didn't give me no 'Well, trust in the Lord, and He'll see you through.' He didn't say nothing. He just looked shocked. Me and my sister said, 'Gosh, we're gonna have to counsel him.'

The next Sunday, the pastor made a remark from the pulpit that offended the woman and her family:

> He made a joke about AIDS with me and my family sitting there, knowing AIDS had hit my family hard. People fell out laughing. I felt that small, and everybody in my family was looking crazy. I forgot what he said, but it was something about a lady in the hospital telling somebody she had AIDS. That was bad. I don't know if he was scared, or didn't know how to touch that situation, or what. It sure shocked me.

The woman and her family left the church and began attending services led by the female pastor who participated in this study. The female pastor recalled that soon after the incident, the woman mentioned that along with the AIDS joke the first preacher had made judgmental statements such as "Yeah, that's why you shouldn't be getting out there doing this and doing that, because you can get AIDS." Although the minister had not called the woman's name, "she was so hurt," the female pastor recalled. The woman and her family

> knew he was talking about them as the dirty sinners. You know, like saying you're just a bad, bad person who got out there and you're just sleeping with everyone. That's what a lot of churches do. That's the way they think you get it.

Ironically, the minister who had made those public remarks was one of six clergy who attended the Task Force's first faith community AIDS breakfast in February 1996.

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The female pastor observed that during the breakfast the man "was just sitting there and didn't say anything."

Adding insult to injury, the minister also refused to visit the woman's daughter in the hospital after numerous requests, the woman said. The co-pastors of the her new church, however, immediately accepted responsibility for the support and counseling of the woman's family. She remarked that "it was amazing how they stepped in. They came to the hospital, they cried with the family, they did it all."

The woman's final painful incident involving the male preacher was his tacit refusal to conduct the girl's funeral. The woman recalled that the minister declined her request by leaving a note with his secretary stating that "he was on vacation, and nobody was to bother him." The female pastor said that "when it was time to bury the young lady, they wouldn't let them have the funeral there, so we had it at our church." The male co-pastor, a professional truck driver, was required to work on the morning of the child's funeral. The HIV-positive woman commented that he "had one hour to be able to come in, do the service, and get to work. And I am very grateful for that."

Reflecting on her daughter's suffering and death, the woman said a prenatal HIV test could have spared her much grief. She remarked, "I would have rather had an abortion, knowing she might have HIV, than to go through all that misery." On behalf of the Ryan White Foundation and with the encouragement of her physician, the woman addressed Congress with a speech about pediatric AIDS and the need for mandatory HIV testing of pregnant women. On the day she visited Capitol Hill, she said

> I got every one of them's signature before I left. I got the feeling that some of the doctors wanted it to be mandatory because of the money.

Although the woman has not disclosed her HIV status publicly, she believes she is

called to speak about her illness so that others living with AIDS can escape their

isolation:

> Awhile back, I couldn't say that. I've had to come to grips with it myself, but it's
> OK now. I just wish I could touch the people that have it, the ones that's hiding.
> If I felt like that, I know they have to feel like that. I have to find those people.
> That's my calling. I have to go where they're at, and bring them in, and tell them
> it's OK.

Outcomes

Figure 23 below depicts the overarching framework for this study highlighting

outcomes, as identified by research participants, in which individuals engage in AIDS
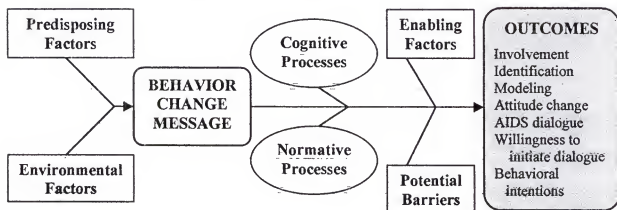
dialogue or comply with AIDS prevention advice.

FIGURE 23: Outcomes of AIDS Dialogue or Prevention Advice

Reactions to the *fotonovela*

One woman was enthusiastic about the wide and rapid acceptance and

dissemination of the *fotonovela* among teens. She remarked:

> I'm seeing that it wasn't very hard to really get the information out about the
> booklets, and that's very exciting. It's very comforting to know that they're
> hungry for so much. And they're not receiving it in the homes.

The overall reaction among the girls' friends was positive, ranging from some saying it was "all right" to others who said they "liked it a lot."

The girls reported that none of their friends seemed embarrassed or shy about discussing the booklet. None of the boys' friends reacted with embarrassment either, although one boy recalled that his friends "were bragging and stuff. Like they were saying like they're scared."

Various girls said their friends asked such questions as "What you doin' in that book?" "Is that your brother?" and "You a virgin?" Several of the boys' friends asked questions about condoms, as well as personal questions like, "Who's got a condom?" and "Who's got AIDS?"

One girl said her friends would "probably be surprised that people their age have AIDS." Unlike the girls' friends, several of the boys' friends expressed fear of getting AIDS. Summing up his conversations with his friends, one boy remarked, "They don't want to die." Similarly, one boy said some of his friends were worried about getting AIDS, especially the ones who have had sex with girls who have babies. He commented, "That girl Sophie, she 13, and she got a baby. I don't know nobody who'll go with her. While she and Mike was goin' together, she was with another dude, doin' it in the woods." Then another boy said, "I wonder if she got AIDS."

One woman observed that while most girls said they liked the booklet, they did not react in other ways. She said the boys were more likely to volunteer comments about the booklet. She added that "it was mainly the guys that really gave me the response that we need to catch them before they get their first feel of a man. I was really shocked." She said the level of interest in the booklet was high among teens in her neighborhood:

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I was more surprised and shocked that they really took the time to read it and to give me a response. 'Cause they're always shoo, shoo, on the go. But it was a really good response. I was looking for something else to come out, but when it came out of their mouths with that, I was like, 'OK.'

When asked if the boys in the focus group might react differently to the booklet than they did, the girls agreed that the boys tend to be less mature than they are. One girl commented that "they probably out there laughing." The boys also expected the girls to react differently to the booklet than they did, for a variety of reasons:

Boy 1: 'Cause they're more mature than boys.

Boy 2: We done jump into it.

Boy 3: And the girls have to think about it.

Involvement in the *fotonovela* story

The story line of the *fotonovela* can serve to involve readers in the text and its message. Just after she read through the *fotonovela*, one girl remarked, "You want to keep on reading to see what happens next." Another said she found the booklet interesting to read because "the pictures draw you in." One girl said the booklet was appealing because girls her age "want to read romance." Another girl suggested, "I think they should do a sequel because I want to see what happens to that girl who wants to wait."

The *fotonovela*'s advice might not become salient until teens find themselves in the situations portrayed in the booklet. One boy wanted to use the booklet to warn his friends before they made a mistake. He commented that "they could look back on this. I could have prevented this from happening."

From the perspectives of several women, the *fotonovela* was an effective educational tool because it was attention-getting, simple, and "makes them think about

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what's wrong and what can happen." Another woman added that "it's best that they have this to really make them think about it."

Identification

When asked if any of the characters were similar to her, one girl said she identified with Tatiana "towards the end, when the girl said she would wait." Then another reinforced the efficacy of this behavior, adding that "she didn't get with somebody and get AIDS."

Although most girls thought the story was realistic, not everyone fully identified with the characters. For example, one girl remarked that "I'm glad I ain't them," while another said "they sound like real people." When asked how the characters in the *fotonovela* are different from her, one girl commented, "We not like them boys."

Portraying teens as *fotonovela* characters can sometimes lead to misunderstandings about whether the youths are portraying themselves, in reality, or simply acting out a dramatic part in a play. For example, one girl pointed to the photo portraying an HIV-positive girl talking in church and then remarked, "This girl right here got AIDS. She done really got AIDS?" Another girl remarked that "this boy on the back, he really look like he has AIDS."

In the future, perhaps *fotonovelas* should bear a disclaimer notice that clearly states that the individuals depicted in the photos are only actors. The teens' comments were unexpected, given that the *fotonovela* only contained photos of teens in the summer youth program, and all these youths were well acquainted with one another. Perhaps the youths were trying to look at the booklet through the eyes of their peers, who might not

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be acquainted with all the youths shown in the photos. For example, one girl commented that "some of these people look like Jamaican people."

Apparently all the girls, including the one who had a lack of reading skills, understood the connections between photos and scripts in the *fotonovela*. For example, one girl remarked that the lettering "goes with the pictures."

Unlike the girls, however, the boys generally did not make a connection between the *fotonovela* content and the photos intended to portray these scripts. This phenomenon may have occurred because the boys simply saw their own images and did not appear to evaluate the booklet through the eyes of others. In evaluating the photos, one boy remarked that most of the photos "ain't got nothin' to do with AIDS. Most of them are people playin' and junk." One boy went so far as to say that the photos "got nothin' to do with the story."

Another boy's remarks about the photos showed that he made no connection between the photos and the content. He suggested:

> You could rearrange the words so like when they're playing basketball, see like where my cousin's getting the dunk – that right there, that's straight – but on the other strips, you could at least switch it around to other different pictures.

Modeling

One *fotonovela* evaluator said she especially liked how Samantha "says no, 'cause her boyfriend Kevin, he's supposed to be the one who pushes her. But Josh is supposed to be talking about what Kevin does isn't cool and stuff." Another evaluator pointed out that "at that age, the girls may be pressuring the guys, too."

After reading the story, several girls said they realized that they do not have to comply with a boy's sexual advances. For example, one girl commented that "you can

get out of it by just telling how you feel." Another added the advice, "Don't have sex if you don't want to."

One boy said his favorite aspect of the *fotonovela* was "the information about girls and stuff." Given that no factual information was provided about girls and that the only content about girls was the dramatization, this boy may have learned something new about girls from reading the dialogue in the story.

Some teens felt the *fotonovela* should include a more involved portrayal of a PLWA so that readers could see that someone like them has the disease. One of the *fotonovela* evaluators said the story should include more information about Carla, the church speaker portrayed as having HIV, and that Carla should talk more about how she lives with AIDS.

Other suggested changes in the story, as suggested by the *fotonovela* evaluators, included having Tatiana and Josh decide that they are old enough to have sex or to show what could happen if Samantha did not say no to Kevin's advances.

Attitude change

Several girls thought the booklet was persuasive in promoting abstinence. One girl commented, "If I was thinking about having sex, if I read this story it would probably change my mind." Another agreed, remarking, "Yeah. It would probably change my mind."

When discussing the lesson of the story booklet, several girls launched into a discussion about abstinence that revealed their differing views about that advice:

Girl 1: Abstinence is the best choice.

Girl 2: It's the best policy.

Girl 3: But no real person, unless you're good, is gonna go without sex.

Girl 4: If you want to be a nun, that's your best choice.

Apparently, the *fotonovela* had high credibility with the teens. One girl remarked that "the statistics are true."

Willingness to initiate AIDS dialogue

Six months after the project ended, a key informant said in a follow-up interview that the most important outcome of her involvement in the study was

> Just being open about AIDS, being able to discuss it, and learning to use whatever tools you can, and to not run away from the problem. We need to find ways to get it out there and not cover it up, to let everyone know it could be them, 'cause it's not so far away. The project showed us how if we can get kids to look for ways to deal with AIDS, then adults can meet to find even stronger ways to reach kids and adults, too.

Another woman who shared the *fotonovela* booklets with several teens in her neighborhood observed that

> The children are not shy about repeating the information. They're really eager to share it with their friends. They're very curious about it.

On the day that the teens were given copies of the *fotonovela*, all the girls expressed willingness to share the booklets with their friends. One girl commented that sharing the booklet would be easy because all the focus group participants lived in the same subsidized housing neighborhood. Many girls mentioned one particular friend who probably would be interested in reading the booklet. One girl said she expected that "some people will talk about it."

People must be motivated by concern before they will be willing to share the booklets, one woman argued. "You've got to care enough that we want to take these

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booklets. We want to help somebody, and we want to stop them before they have to pay this big price."

The willingness to share the booklet may be related to perceived susceptibility to AIDS. During a focus group, one girl remarked to her friend, "You not scared of anything. Ain't nobody but me gonna share it."

When asked how she might react if she were asked to share the booklet with her friends, an evaluator speculated that she would

Probably take the booklet home, put it on my organ seat, look at it for a week, then the day we're supposed to go back I'd show my next-door neighbor and get their thoughts. If I remembered to do it.

Even girls who did not consider themselves popular were willing to share the *fotonovela* with their friends. For example, one girl remarked, "I only have one friend, Dee Dee. I'll give it to Dee Dee." This was not the case with the boys. When asked what he might say to his friends about the booklet, one boy simply said, "I ain't got no friends."

AIDS dialogue

When asked what kinds of things they might say to start a conversation about the *fotonovela*, several girls suggested a direct approach and did not seem shy about talking to their friends. For example, one girl said she would simply say, "I got a booklet from a friend, and I want you to read it."

The introductions the girls actually used in sharing the booklets were a little more detailed. For example, one girl said, "I told them this was a project that we did, and to read it and read it carefully." Another said, "I just told them to read it, and read the raps."

Several girls said they would simply advise their friends to read the booklet, now or in the future. One girl said she would insist that her friends at least have their mothers read it to them: "I'd say, you gotta read it, or give it to your momma. And she will read it to you."

For someone to just read through the booklet may not be sufficient. One girl said she would tell her friends to "read it and pay close attention to it."

One boy said that when he approached his friends to talk about the *fotonovela*, he told them things like, "You're really good friends. This could be your life. So, that's the point in talking about things, you know."

Another boy said all his friends responded when he showed them the booklet. All the boys said they talked to their friends about AIDS or sex when they shared the booklet. One boy said this was easy because "it's like, we always talk about it." Another said he asked his friends whether they had a condom and told them that he had one, while one boy similarly recalled that he explained how to use a condom. Another boy said he talked about drugs, "uh-huh, some main drugs, uh-huh."

A good way for an adult to start a conversation about the booklet with a teenager, one woman suggested, is to take a young teen aside and say, 'Hey, I've got this pamphlet here. Can I show you this? You may not know, but can I take this one minute and help you?'"

The booklet is especially useful, one woman contended, for parents who want to initiate a difficult conversation with their children. She commented:

> This here, to me, is something that works when you're trying to talk to your daughter or something about AIDS. 'Cause I know how it is when I work, and I have girls at home every day. It's hard.

The one-page list of tips for using the booklet was well received among the women. One remarked that this list was "really good" because

> I mean, this is something you can use to help talk about it. This is like, straightforward, and you can memorize a couple of these and kind of interject them when the person is ready.

Six months after the study ended, a key informant commented that participants in the youth focus groups still were circulating copies of the *fotonovela* among their friends. She remarked that

> Some people in the church still can't believe it was our kids' pictures in the booklet. The youth need to keep AIDS fresh in their minds. We don't want to skip over any way that we can get the information out to kids and their parents.

Contexts of *fotonovela* dialogue

One woman observed that many people seemed to be talking about AIDS around her neighborhood and "wanted to know more" after she distributed copies of the booklet. She shared this anecdote:

> I happened to be passing by, going to my mailbox. I heard a discussion about AIDS, but I didn't see nobody. And I go, 'Well, praise the Lord.' Maybe it was something else, but so I told my neighbor, 'Let me go, and I'll bring the information back. Everybody can't go.' And she said, 'Well, if I see you, I'll stop in and get brochures.' And I said, 'Fine, I'll pass the word.'

The intended use of the booklet was not limited to peer or parent-child interactions. One woman recommended to her friends that "if you don't have kids to share it with, you can share it with young people to make them more aware that these things can happen."

In some cases, an adult who has weak social ties with youths can be at least as effective as a parent, sibling, or close friend in motivating teens to read and discuss the booklet. A woman who shared the *fotonovela* door-to-door with eight teens said she

often talks casually with youths who come into her home-based store to purchase things. She remarked that even though she did not know them personally, "by them knowing me, I guess they felt a little bit more secure with me, knowing I won't tattle and stuff."

She said her decision-making process for targeting individuals for *fotonovela* distribution and dialogue was based on prayer. She explained:

> I picked it up a couple of times, and I said, 'Naw, I'm not gonna do it today.' Then I picked it up again, and I said, 'Naw.' I kept saying 'naw' 'till I picked it up and just walked out the door. And I said, 'So which way do I go?' And I turned this way, so I was like, 'OK, I'm goin' this way then.' The Lord guided me to those people.

The woman said she went door-to-door in her neighborhood, handing out copies of the booklet to teens living in the low-income apartments:

> They asked did I have another pamphlet, and I gave them the pamphlet. And they said they was going to talk to their cousins and stuff about it, and show it to them, and ask them how they feel about the questions. I asked them to use the questions on the sheet as well. And they said, 'OK.' Some of them are waiting on me to come back and let them know when we'll have a group session at my place.

After she talked to various teens in their homes, several said they "had some nephews and nieces, and they'd have them read it. I heard back from one of the guys who said his nephew really tripped out on it. I was like, 'Whoa, this is really goin' on, you know.'"

Another woman remarked that the teens seemed "hungry" and "ready" to talk about AIDS. One woman remarked that "they really wanted to know" and that because of the *fotonovela*, "we got a start, digging down deep and stopping our young children from having their way. We got to stop them before they get that first feel."

In visiting youths in their homes, one woman found that while most were receptive to the booklet, many of their parents or caretakers were not interested in reading

or discussing it. Despite this general disinterest, however, the woman offered to use the *fotonovela* to assist a grandparent who was squeamish about discussing sex with his granddaughter:

> I was glancing over the pamphlet again, and a neighbor came up behind me and said his granddaughter came to him asking about sexual activities and diseases. And he was like, 'You'll have to talk to your momma about that.' She had just told him, and while I was standing there talking to him, I gave her the pamphlet. He told me she's ready to talk about those things. He said he'll send her over to my house. I said 'I can sit down and explain things to her at my house, but if I explain it in front of you, then if you have any objection to what I'm telling her, you can say that.'

All the girls said they shared the booklet among friends in their neighborhood. One girl said she distributed some booklets by inserting them in her neighbors' doors. A key place for *fotonovela*-related dialogue among the boys was the men's bathroom at school. Other boys said they talked about the booklet while walking to school, in church, and in their neighborhood. Several women agreed that their neighborhoods were the best places to distribute the booklets. One woman said she gave copies of the booklet to teens in her church.

The worst place to distribute the booklets, several women argued, would be on the streets. One woman said the streets are a poor environment for this kind of dialogue because "by the time you give it to them, they're walking away." Another woman added:

> They'll just throw it in the garbage can. Or they'll hold it and walk a block down the road, 'cause they're like, 'I don't want her to see me throw it away.' They hold it, and you think they're gonna take it. And then you walk behind them, and you see it laying on the ground.

Given that the booklet was not intended to serve merely as a handout, sharing it with individual friends was sometimes a time-consuming task. Recalling how his friends responded to the *fotonovela*, one boy commented that "it's like, they take their time."

Although the primary message of the *fotonovela* was abstinence advice, many teens used the booklet to educate their friends about using condoms or "rubbers." One girl recalled that "the best thing I told her was that – I said if she do that kind of stuff, to use one of those things." One girl said she "had to tell them how to use a condom, though. They didn't know how to use it."

The focus group discussion about AIDS dialogue may have effectively modeled the kind of conversations the boys could initiate with their own friends. One boy speculated that talking to his friends about AIDS would "be a day like this, where you'd be like – like this day, we talking about it."

Although most teen participants expressed willingness to share the booklets with their friends, several girls contended that their friends probably would not be interested in sharing the booklet with other friends. Similarly, when asked if their friends would likely give the booklet to other friends, one boy said yes, while another boy said they probably would not because "they gonna throw it away."

This finding highlights the need for targeting youths through moderated discussions, script writing, interpersonal skills training, and other activities to promote their involvement in learning and behavior change. Merely handing out copies of the booklet, without this kind of interpersonal involvement, might interest youths enough to get them to read the booklet and talk about it, but not enough to motivate them to share it with others.

Behavioral intentions

A couple of the women provided behind-the-scenes anecdotes about how the teens in the summer youth program responded to the focus group discussions and *fotonovela* project.

One woman, who said she often counsels many of these teens, reported having conversations with several of the girls:

> I tried them out afterwards and listened to their little comments to see what they were going to say. I had them tell me, 'Well, you know, I'm going to wait. I'm not going to do that.' And most of the young ladies said, 'Now, we're not going to do it.' I was really proud of them, 'cause I didn't know how hard it had already been. Most of them was 12, 13, and on up. They were looking at the booklet more closely. And even the girls who were 15, 16 and older told me they haven't had sex, and they weren't going to have it because of these different things that came up. And one of them said, 'What about high school? Then I may have sex.' Still yet, when one of them said that, we had a discussion and took it a little further. They understood it was not something you just don't do, but they still need to take care of themselves.

Another woman also initiated discussions with several teens after they participated in the *fotonovela* project. She recalled that a couple of teens told her, "My momma's crazy. She'd hate me. She told me she'd kill me if I ever did something like that." But reflecting on that remark, the woman said:

> You know, if they afraid of their momma, they're all ready to do that and they wanna talk to you. I'm like, 'You're not gonna wait till you're pregnant to deal with me, if I find out you're doing this,' and a lot of them are like, 'Oh, no. I'm not going to do this.'

The next chapter, Summary and Conclusions, will offer a more in-depth conceptual framing of key findings, as well as suggestions for public health practitioners, a discussion of the study's limitations, and ideas for future research.

CHAPTER 5
SUMMARY AND CONCLUSIONS

Summary

This exploratory study is a qualitative analysis of the factors that can promote AIDS dialogue and predict compliance with AIDS prevention advice among African Americans. The objectives of this study were to modify existing health behavior theory, develop directions for future research about culturally specific, church-based HIV prevention strategies, and to reveal factors that block or empower constructive AIDS dialogue in these settings. Through the use of a *fotonovela* as a tool for both data collection and AIDS education, this study helped identify the settings, strategies, tools, and topics that can involve African American individuals in AIDS dialogue in both religious and non-religious contexts.

The data collection methods consisted of 10 groups encompassing 85 focused interviews with adolescents and women, 13 in-depth interviews with clergy, church members, and AIDS organization leaders, and 30 participant observations of meetings and other events of AIDS organizations and churches.

Adolescents collaboratively developed skits and "raps" for a *fotonovela*, a photo-illustrated comic book, for use as both an HIV prevention tool and as a device for gathering information about how lower-income women and adolescents engage in AIDS dialogue with others within church-based social networks. The *fotonovela* was a trial intervention, a small-scale test of a new idea, and thus it was not intended to serve as a full-scale intervention in the African American community. Rather, the booklet was

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created primarily as a tool for gaining access to AIDS-related attitudes, beliefs, and insights into the norms and structure of social networks through which a *fotonovela* could be shared. The *fotonovela* was not designed for mass distribution, like other AIDS prevention materials, but it was intended to serve as a "key to unlock doors" to dyadic and small group discussion about the facets of AIDS prevention most salient to the individuals involved in the exchange of information, opinions, and concerns.

The insights and observations of study participants were used to develop new theories, ideas, and hypotheses for future research projects, as well as to provide advice and intervention implications for public health practitioners. The analysis was not intended to reflect the views of all African Americans, nor extrapolated to explain the attitudes or behaviors of African Americans with demographic characteristics similar to those of the study participants. The research design addressed two key questions:

- What are the inroads and barriers to AIDS dialogue within the black church?
- How can existing, church-based social networks facilitate AIDS dialogue?

An organizing theoretical framework consisted of eight domains: predisposing and environmental factors, message design and delivery, cognitive and normative processes, enabling factors, potential barriers, and outcomes.

The theoretical framework included constructs from 14 existing behavior change models: the AIDS Risk Reduction Model (Catania, Kegeles, & Coates, 1990), Diffusion of Innovation theory (Rogers, 1995), Elaboration Likelihood Model of Persuasion (Petty & Cacioppo, 1981), Extended Parallel Process Model (Witte, 1996), General Model of Communication (Gerbner, 1956), Health Belief Model (Becker, 1974), Input/Output Matrix (McGuire, 1989), Persuasive Health Messages Framework (Witte, 1995),

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Protection Motivation Theory (Rogers, 1975), Social Cognitive Theory (Bandura, 1994), Stages of Change model (Prochasta & DiClemente, 1984), Theory of Planned Behavior (Ajzen, 1988), Theory of Reasoned Action (Fishbein & Ajzen, 1975), and the Transformation Model of Communication (Kreps, 1994).

The comprehensive approach guiding the study utilized this overarching framework, as well as an innovative channel that served as both a trial intervention and data collection tool. This strategy was needed for several reasons:

- The disproportionate AIDS rate among African Americans, compared with other U.S. populations, highlights the urgent need for innovative prevention strategies.
- Existing health behavior models, while comprehensive in scope, are not culturally specific enough for African Americans in part because many of these models were developed through surveys of predominantly white university students.
- The African American church, while theologically conservative, holds great promise as a key community institution within which certain sensitively tailored AIDS prevention interventions could be initiated among opinion leaders.
- The extended family network within the churches and neighborhoods of the black community can serve as an excellent conduit for AIDS dialogue, including the spread of specific AIDS prevention recommendations as community innovations.

- The oral tradition in the black community can facilitate storytelling, skit writing, and rapping about AIDS risks and prevention.

- New strategies for reaching lower-literacy minority individuals are needed as prior research shows that mere exposure to AIDS prevention literature and public service announcements does not lead to long-term behavior change. *Fotonovelas* could be a viable alternative because they appeal to emotional interests of readers, are kept and re-read for entertainment, are passed along through social networks, and are more accessible to lower-literacy individuals who cannot or will not wade through statistics and other facts within standard AIDS prevention literature.

The data collected in this study was analyzed in light of existing and emerging theory. The analysis revealed contexts, opportunities, and benefits of AIDS dialogue, as well as popular and prescriptive norms of AIDS knowledge and attitudes, health beliefs, religiosity, sexual behaviors and scripting, substance use, and source credibility.

Key Findings

The data analysis yielded a number of key recommendations for the design of culturally relevant AIDS prevention interventions targeting African American youth. The following discussion highlights these recommendations.

The theoretical framework in Chapter 2, based on a synthesis of existing theory and empirical findings, was comprehensive in scope because it integrated key components of 14 behavior change theories. Thus, this organizing model was useful as an overarching framework for the data analysis, and in most cases the general constructs of the model provided appropriate "intellectual bins" (Miles & Huberman, 1994) for the

broad classification and interpretation of data-texts. However, given that the analysis was inductive and that various themes emerged through collapsing various data labels and other codes, some deviations from the literature-based model emerged. The following list summarizes 17 key deviations from the original model proposed in Chapter 2:

- **Religiosity constructs**: While religiosity was proposed as a general demographic, predisposing factor, the research participants provided numerous distinctions about their own religious beliefs and practices that could influence AIDS preventive behavior, and these views were not elicited in the church-related questions of the interview protocols.

- **Sexual abuse**: Adult women highlighted sexual abuse and incest as key risk factors for African American youths, which is significant because no question elicited opinions about these issues, nor were these issues addressed in the basic literature about AIDS risks among African Americans.

- *Fotonovela* **evaluation:** Many dimensions of the *fotonovela* intervention, not covered in the existing literature, emerged through the participants' evaluation of the booklet. These included: visual appeal, image processing, age appropriateness, realism, use of raps, humor appeals, and barriers to dialogue.

- **Sexual revenge attitude:** The idea that HIV-positive individuals, particularly women, may seek revenge through deliberately infecting others emerged as an unexpected attitude. This topic came up, however, because focus group participants commented about the sexual revenge theme of the "On the Pillow" video.

- **Pastoral norms:** In addition to the general prescriptive and popular norms among teens and adults, some focus group participants were particularly concerned about

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expected behavior and attitudes among black clergy. While the youth appeared to discuss this topic because they were reacting to a minister-character in the video, the women discussed the issue because a sex scandal involving a prominent local African American minister had appeared in the newspaper that week.

- **"Watching for the Signs":** Among the women in both focus groups, a dominant theme of all discussion was an African American woman's responsibility to watch for signs of risky behavior among her own and others' children and to intervene if needed.

- **Heritage reminding:** While heritage reminding is an AIDS prevention strategy recommended in some literature about African American culture, the focus group participants emphasis of this topic was spontaneous and not prompted by questions.

- **Achievement orientation:** Many key informants and focus group participants voluntarily suggested strategies for giving youth a vision for the future so that they will be more motivated to protect themselves now. This topic may have been particularly salient among the youth because they were daily participants in a summer after-school enrichment program targeting disadvantaged teens. Similarly, many women were from the same low-income neighborhood and wanted to help their children clear the many hurdles along the path to a college education.

- **"Making it real":** Participants from every focus group emphasized that AIDS prevention campaigns must make the disease and its consequences seem real, even if these messages or images scare people. Some criticized the fotonovela for being "too mild."

- **Telling "our stories":** Many women emphasized that telling personal stories about past experiences to youth is an important way to reinforce community AIDS prevention efforts. This suggestion appears to be grounded in the oral tradition.

- **Forging inroads:** Many leaders of churches and AIDS organizations were particularly enthusiastic about offering ideas for forging inroads for AIDS dialogue within the churches. While this was a primary objective of the study, it was not addressed in the existing literature.

- **Compassion:** Many key informants and focus group participants emphasized that compassion toward everyone is a Christian duty that could be a cornerstone of church-based AIDS programs.

- **Response efficacy:** Although the response efficacy of condoms was suggested as an enabling factor in the literature, the female participants generally did not express confidence in condoms' ability to protect individuals from HIV infection. Only the boys appeared to believe in the efficacy and necessity of condoms.

- **Familiarity:** An unexpected barrier to AIDS dialogue was familiarity with AIDS information – the idea that "I don't need any more AIDS information because I already know enough."

- **Desensitization by drama:** Another unexpected barrier to AIDS dialogue was the possibility that an AIDS message embedded in a dramatic format can be interpreted as mere fiction and could trigger a denial response among individuals who are heavy users of television and other entertainment media.

- **Church as protection:** Many women believed that active involvement in a church can actually lull people into a false sense of protection, which could place them at greater risk if they believe that other church members are inherently "safe."

- **Expectation for divine healing:** While some women suggested that divine healing offers hope for people living with AIDS, the underlying premise of this healing is that the victims are ultimately to blame – that they cannot be healed unless they have enough faith, get rid of sin, or receive salvation. This victim blaming could block social support.

Even fellow ministers often blamed clergy for prohibiting AIDS dialogue in the churches. Many women nevertheless viewed themselves as "torch bearers" of HIV prevention in church settings, as well as community sentinels, surrogate parents, and counselors. AIDS dialogue is rare but possible within church-based social networks. It can be stimulated through interpersonal interventions sensitively tailored to address condom use, AIDS stigma, homosexual behaviors and other religious taboos, while utilizing Christian principles such as evangelism, prayer, behavioral accountability, and divine guidance.

Cultural similarities existed among African Americans of both sexes and of all ages in the ways they used the *fotonovela* as a tool for discussing AIDS-related issues. The physical and social settings for this kind of dialogue appear to have a critical impact on the likelihood that this kind of dialogue will occur, as well as its intended outcomes.

Prevention messages that include heritage reminding and achievement orientation may be more effective than direct behavior change recommendations in persuading African American youth to protect themselves from the consequences of unsafe sex.

AIDS prevention interventions targeting African American youth should account for developmental and gender differences in attitudes about sexual involvement. Youth should be encouraged to contribute scripts, raps, and ideas in the collaborative development of AIDS prevention materials. The *fotonovela* may be a particularly effective tool for building a sense of enthusiasm, momentum, ownership of AIDS prevention issues, and perceived self-efficacy in educating others and maintaining healthy behaviors.

Women can play important roles as community sentinels, surrogate parents, and counselors, if they watch for signs of risky behavior among youth and present themselves to youth as non-threatening sources of information and advice. Many women who are members of politically influential social networks within churches could serve as innovators in creating AIDS ministries for outreach and church-based AIDS education.

An AIDS intervention targeting African American parents could address the benefits and disadvantages of directive versus mutual approaches to parent-child communication, as well as strategies for initiating sexual dialogue with teens. Parents could be encouraged to use a *fotonovela* as an "ice breaker" or discussion starter tool.

The social environment and lack of media access among low-income African American youth should be considered when selecting channels and designing messages. Media-based interventions with a strong interpersonal component and word-of-mouth

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strategy for dissemination may be more likely to succeed in changing attitudes and behavior among residents of low-income housing neighborhoods.

Church-based AIDS prevention interventions could:

1. Appeal to beliefs about practices that constitute a Christian lifestyle, such as Bible study, prayer, church attendance, spiritual salvation, confession of sin, listening for God's voice, self-control, behavioral accountability among believers, evangelism, introspection, divine gifts and callings, and unconditional love and compassion for others.

2. Emphasize forgiveness and support of those whose behavior has deviated from Biblical teachings, particularly individuals involved in extra-marital sex, substance abuse, homosexual relations, or sexual abuse of children.

3. Address stigma toward PLWAs, including lack of social support, fear of contagion, just world belief, dehumanization, condemnation, avoidance of others' pain, and gossip. Discuss divine healing from a Christian perspective in a way that promotes support and prayer for PLWAs but does not condemn those who do not receive physical healing.

4. Address religious taboos by showing how AIDS issues are addressed in the Bible, how frank discussions about risky sexual behavior can be a form of compassionate outreach, how various spiritual gifts and callings can be used to help curb the spread of AIDS, why "good" Christians need to think about AIDS issues, and why denial and fatalism are barriers to saving others' lives.

AIDS prevention efforts targeting African American teens should encourage them to consider and discuss hypothetical situations, such as a teen pressuring another to have

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sex, a partner refusing to use a condom, a friend confessing HIV infection, or an adult willing to talk about sensitive sexual issues.

The cultural norms of the extended family and the oral tradition within those networks afford exceptional opportunities for the dissemination of AIDS prevention messages as facilitated by credible interpersonal dialogue. An AIDS prevention message focusing on "the search for a good man" might appeal to many African American girls and single women who believe the pool of eligible bachelors is severely limited. This message could warn them about the dangerous belief that religious men are low-risk sexual partners.

Community-based AIDS prevention efforts must address beliefs about the local threat of AIDS before individuals will perceive themselves to be susceptible. Perceived threat also is localized to sub-populations of a city, such as the black community's common view that AIDS is a white gay disease.

While an abstinence message may be the only sex advice that many African American churches can promote, given religiosity barriers, this advice must be carefully framed so that it appeals to cultural norms of good Christian behavior while reinforcing the message that any "slip-ups" require use of a condom. Dialogue about condoms in church generally may be more acceptable in private one-on-one or small group settings and less acceptable when promoted in AIDS prevention materials or public speeches.

Emphasizing consequences of early pregnancy, in addition to HIV infection, may increase motivation among some teens to practice AIDS preventive behaviors. The advice that teens should not value a partner more than their health could help reinforce this dual message.

The use of visual media such as *fotonovelas* or videos may stimulate attention, involvement, learning, and memory more effectively than non-visual media, particularly when the use of these media are combined with interpersonal or group dialogue in familiar, everyday settings.

Detailed Findings

The following discussion provides an overview of findings in the context of religiosity, AIDS prevention strategies, cultural norms, and social psychological theories of behavior change. Theory-building ideas are discussed in relation to the conceptual framework that was used to organize the literature review and results in the previous two chapters. This discussion also includes recommendations for the practical use of *fotonovelas* in targeting African American teens with AIDS prevention advice.
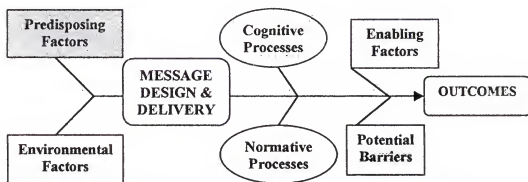

FIGURE 24: Predisposing Factors in AIDS Prevention

Predisposing factors

Demographics

Higher age may be a predictor of perceived self-efficacy and perceived susceptibility to AIDS among African American women. Even if most church-going African Americans are middle aged and older, the primary target of church-based AIDS education efforts should be adolescents.

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Pre-teen girls may have a greater concern about the consequences of sex and AIDS than boys do at that age. This finding is consistent with that of Henker (1995), who found that among younger teens, girls are more likely than boys to carry a worry burden about AIDS, death, and other global concerns. In addition, Reitman (1996) found that among low-income African American teens, boys are more likely than girls to engage in high-risk sexual behavior, even if they have higher perceived susceptibility.

Girls may perceive that boys act immature, disruptive, or indifferent when presented with AIDS prevention advice, even if the boys may actually be listening to the advice. Pre-teen boys may enjoy viewing AIDS prevention media because they identify with the sexual behaviors being portrayed, not because they feel fear about possible consequences.

Sexual activity among young children may be interpreted as an expression of curiosity, the initiation of sexual involvement, or evidence of molestation. Ascertaining motives for sexual involvement among African Americans 10 years old and younger is needed to develop appropriate AIDS prevention literature for these children.

Socio-economic status among African American teens may be linked to their selection of AIDS information channels. Teens from a higher socio-economic background may prefer media as their primary source of AIDS information, particularly television, radio, movies, and albums. Teens from a lower-income background may receiving most AIDS information from sex education classes at school, from hearing a guest speaker, or from their parents, but not from the media. Lower-income women who did not receive AIDS education in school may have access to information through personnel training, public health outreach workers, or from magazines.

Lower-income, African American teens may rely on interpersonal channels more heavily than mass media channels because of insufficient access to media or because they live in a sub-culture within subsidized housing areas that more strongly reinforces word-of-mouth communication. Jane (1990) found that adolescents whose mothers were employed generally spent more time with radio and television. This finding would help explain lower broadcast media use among lower-income teens if these youths were less likely to have a mother who works outside the home.

Religiosity

African American teens may tend to believe that regular church attendance ought to be an important part of a teen's lifestyle, even when they see themselves as less religious than adults. Their motives for attending church may include enhancement of self-esteem, entertainment, or to have an emotional worship experience. Boys may be more reserved than girls in their outward expressions of worship except when a male religious leader provides cues for appropriate male behavior in that context.

African Americans of all ages may be more likely than whites to view church as a kind of extended family and as more than just a place for worship and religious expression. African American teens may perceive themselves to be more religious than white teens and that black teens in general are raised in a culture that promotes higher religiosity. However, they also indicated that black teens must cope with more problems or with more serious problems than white teens do. Some African Americans may be reluctant to attend church if they feel the churches are not actively trying to communicate with the black community about important social issues. Rising apostasy among youth may be partly attributed to parental leniency in requiring regular attendance.

Reading the Bible daily is considered an essential part of being a true Christian, and it is considered a guide to appropriate and healthy behavior. Christians read God's Word to discern which behaviors are appropriate and sinful according to various religious rules in Scripture. A primary goal of a Christian lifestyle is to emulate Jesus. Committing sin may be forgivable but it is considered dangerous. Reading Scripture helps Christians identify their own and others' sins and put these "mistakes" into perspective.

A tenet of African American religiosity appears to be the belief that when a Christian pursues a daily walk with God, the Holy Spirit "speaks" and guides the person's behavior from one moment to the next. A Christian's reliance on this divine inner spirit could be a barrier to the prevention of risky behaviors, as it could lend a false or irrational sense of protection, or that it could actually enable a person to effectively banish such behavior from his or her life.

While an irrational decision is driven by emotions or physical desires, and a rational decision involves the weighing of costs and benefits, a spiritual decision is based on guidance from God's voice, Bible interpretation, and other Christians. Living as a mature Christian involves surrendering control of oneself to God, while recognizing the consequences of disobedience to His will. Mature Christians fear hurting Jesus as much as hurting themselves. This spiritually empowered self-control could prevent costly mistakes.

In addition to seeking God's voice through prayer, Christians are expected to seek accountability for their actions from other Christians. Even those who have a history of risky sexual behavior are expected to refuse temptation to do those things again.

Christians who are diligent in praying and reading the Word believe that their inner spirit will guide and protect them when they are confronted with temptation. Some believe this inner advisor should be consulted as an ethical decision-making guide, not as a fortune teller.

The efficacy of Christian salvation and spirituality in preventing "slip ups" may be challenged by some Christians, particularly when the failings of prominent religious leaders are publicized. Many Christians believe that to be spiritually protected, a person must receive both salvation and baptism of the Holy Spirit. If Christians receive these gifts but still slip up, they may be seen as weak because they have not devoted enough time to prayer and confession of sin in order to promote a level of spirituality sufficient for protection.

Christians may identify themselves as cocooned within a protected subculture that shelters them from the sinful world and the consequences of sin, while people who have not received salvation may be labeled as "out there." The lifestyle of the world "out there" may include street culture norms, partying, substance use, promiscuity, and rejection of church teachings. Christians may tend to assume that people who are "out there" are less rational and non-spiritual, because their lives are seen as less principled and disciplined. Conversely, Christians who are "in the Word" may believe they are acutely aware of actual dangers around them because they see themselves as frail sinners. They believe the "wages of sin is death," which could include physical death. Non-Christians might have lower perceived susceptibility if they believe their social status protects them from harm, whereas some Christians may not have this barrier if they perceive they are just as vulnerable to sin as a drunken bum or prostitute.

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Living spiritually may lead to greater introspection, which would be expected to lead to more beneficial decision-making. Caring about the welfare of others also may help people make healthier decisions. Highly religious Christians may see themselves as more caring than others and believe that God constrains them from selfishly hurting others. A primary motive for activism among Christians is belief in a divine calling, a specific instruction from God manifested through prayer. A church-based AIDS prevention campaign could appeal to values of caring, spiritual introspection, and divine calling to help others.

The difficulties and tragedies of life "out there" may draw some individuals into the church as they seek comfort and support. However, given that Christians are supposed to serve as models of morality to non-Christians, many Christians may fear that their own mistakes will discourage the people who are living "out there in the world" from seeking salvation.

The concept of AIDS-related dialogue could be framed using common experiences of community evangelism, and AIDS dialogue and evangelism could be viewed as similar tasks in terms of importance, seriousness, urgency, and strategies. The strategies recommended for the effective dissemination of a *fotonovela* are very similar to those used by evangelists who share religious tracts using interpersonal dialogue. Conversations about AIDS and sexuality could be embedded within the dialogue of evangelistic outreach as well. This kind of dialogue could be framed as a holistic concern for a person's spiritual, emotional, and physical well being.

The concept of gardening -- "planting a seed" and letting God "do the watering" -- is a central tenet of evangelism. Although a Christian may feel an urgency to prevent a

spiritual downfall, the empowerment for prevention is up to God, and the decision to adopt the advice is up to the listener. The recipient of the advice is seen as soil for planting, and God must provide conditions for the germination of the seed. In other words, a person will not change until they perceive a need for change.

A barrier to sharing a salvation message with non-Christians is their skepticism about praying to an invisible supreme being. Given that HIV is an invisible virus, usually transmitted without notice and infecting a person for many years without symptoms, perhaps a lack of "faith in the invisible" could be framed as a barrier to perceived susceptibility to AIDS as well as a barrier to religious salvation among African Americans.

Even if youths who feel pressured by a salvation message, Christian evangelism could be used to draw them into a church where they can receive love and acceptance within an expanded social network, particularly if they do not receive this validation at home. A positive spiritual environment could enhance a person's self-esteem and promote self-efficacy in maintaining a healthy lifestyle. If spiritual love within a church could satisfy a basic need for validation and fulfillment, some people might become less motivated to engage in risky sexual behavior as a result. A possible key to AIDS prevention might be to ask questions about spiritual needs and then attempt to fulfill those needs through individually tailored spiritual and social involvement in a church community.

The social and political realities within most congregations often may inhibit the flow of love, compassion, and open dialogue that many non-Christians want to see when they visit a church. Further, when youth or non-Christian visitors are uncomfortable

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participating in church activities or if they are expected to present themselves as "saved" Christians, this pressure may lead them to withdraw or rebel. Some Christian parents fear that their attempts to involve children in church may eventually drive the youth away from an institution perceived to be a stable system of social support and principled morality. Others complain that youth dismiss all their attempts at behavioral discipline as old-fashioned religiosity.

AIDS risk factors

Many African Americans may "slip up" at some point and engage in risky sexual behavior even when they know better. A "slip up" may be seen as inevitable and unavoidable, an action beyond rational control. Although traditional wisdom may argue that learning from one's mistakes is the most effective kind of learning, an HIV prevention message must emphasize that it takes only one mistake to contract the virus.

The most common "slip-up" among African American adults may be marital infidelity. Even if African American women believe their husbands might "slip up," they may seldom use condoms during conjugal relations. If this were true among many African American women, it would highlight the need for a culturally sensitive strategy in which women are taught to educate their partners about AIDS risks.

Alcohol and drug use

Some reasons that African American teens want to drink include the perception that drinking is common among peers, peer pressure, prior drinking, discussion about drinking among friends, the desire for intoxication, the desire for fun and excitement, and seeing physical evidence that others are drinking. Some boys admitted secretly drinking

during school or church-sponsored youth activities. Alcoholic drinks of choice included beer and whiskey, and some teens apparently start drinking at home with their family.

Even women with a past lifestyle of partying believed that drinking responsibly is more important than choosing the right partner for a monogamous relationship, because they do not want to give any man the opportunity to take advantage of them sexually.

African Americans are perceived to be more at risk of HIV infection than whites because of widespread illicit drug use and sex trading for drugs on the streets. The use of crack and other drugs has become a central component of street culture, even in smaller cities like Gainesville. Many African American children and teens from low-income housing areas often smoke marijuana and use other drugs or sell to their friends in public places without fear of legal or parental punishment.

Emphasizing alternatives to drug use may be more effective than telling youth to "just say no" or that drug use is morally wrong. Likewise, hearing a personal testimony from a former drug addict could make a more lasting impact on youth than having a parent or minister lecture them.

Crack use was considered more stigmatizing among girls than among boys. Some girls feared that discussing drug use norms might somehow implicate them. The ones who use drugs secretly lead a double life, striving to score brownie points with teachers or other adults without bragging about their private habit to friends.

African American teens may use drugs because of easy access, a need for excitement, the desire for something to do, for physical pleasure, or because they need an antidote for stress or depression.

A key reason that girls said they would not use drugs is fear of getting "bad stuff," drugs that contain toxic chemicals. The boys, however, were more concerned about the possibility of imprisonment than any health risks. Other than poisoning, other health risks cited by boys and girls included overdosing and impaired judgment, and injury from loss of motor skills.

Several teens wanted to learn more about drinking and drugs before middle school, so that they will be better prepared to deal with future pressures.

Some African American boys try to appear "macho" by displaying their knowledge of street culture, drug practices, hangouts, addicts, and paraphernalia. However, none wanted to be known as a "crack head," and some would even rat on their friends.

Some boys would be willing to walk out of a situation where drugs are being used if they feared peer pressure, punishment from parents, or the possibility of violence. Girls, on the other hand, may be more likely to avoid making waves in those situations by hanging out and pretending to participate. The girls were more likely to say that using drugs is acceptable, in moderation.

Although many African American churches freely discuss the dangers of drug and alcohol abuse, they do not acknowledge the possibility of substance abuse within their congregations.

Sexual abuse

African American girls who are sexually abused are at risk for HIV infection because of unprotected sex with the abuser and the likelihood that they will initiate sexual activity with peers at an earlier age, as well as other risky behaviors rooted in emotional

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trauma resulting from the abuse. Although incest is taboo, the practice may be more commonplace among African Americans than among whites because of social norms within extended family networks. A common perpetrator of sexual abuse is a mother's boyfriend.

Previous studies have shown that African American girls are more likely to become sexually active at a young age when they have had a forced sex experience. Nagy (1994) found that victims of sexual abuse among eighth-grade teens were disproportionately African American and female, and both girls and boys reported significantly higher levels of risky health behavior and risky attitudes than those who were not sexually abused. In addition, sexually abused teens were more likely to reside in single-parent households.

Offering confidential, professional assistance to families that hide these taboo incidents may give girls a way of escaping an abusive situation. Female members of a girl's extended family also may provide shelter and assistance. While homosexual molestation of boys may be perceived as less common, it still exists. Some child molesters may hide within the church because the status of being a church member can shield them from suspicion.

Condom use

Most boys made a strong connection between condoms and HIV prevention because they have been taught about condom use in school. But when asked what they might do if a woman tried to prevent them from using a condom, boys offered various responses. While most would insist on using a condom, others might be willing to have sex without it. DiClemente (1996) found that high assertive self-efficacy to demand

condom use among African American adolescents predicted consistent condom use more than other factors. The factors that predicted consistent condom use to a lesser degree included perceived peer norms of condom use, high impulse control, male gender, and younger age. These findings, combined with related findings of the present study, indicate that AIDS prevention efforts targeting African American teens should encourage them to consider hypothetical situations in which a sexual partner refuses to use a condom.

Most women approved of condom use to prevent disease transmission, even though they considered themselves to be highly religious Christians. Some women believed that couples do not use condoms consistently when one person is afraid of hurting or offending the other or when they become blinded by the heat of passion.
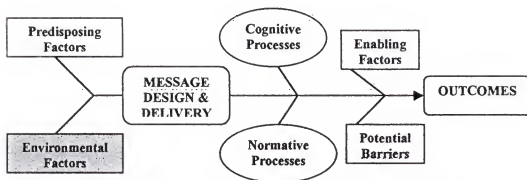

FIGURE 25: Environmental Factors in AIDS Prevention

Environmental factors

Family norms

Church members can serve as an extended family, particularly for support of a person going through a crisis. African American youths who do not have a mother or father in the home often are informally adopted by non-relative members of their

extended families. Rather than looking to a parent as a role model, they often choose a minister or older sibling. However, this situation can lead to disappointment and loss of guidance for younger members of an extended family.

In the African American community, premarital sex often may be defined as statutory rape for the purpose of punishing young men. Teen pregnancy and common law marriage may be more accepted in the black community than among whites. Most married African Americans may not practice safe sex with their spouses, either because they trust their spouses completely or because they accept the risks associated with possible infidelity. Taking marriage vows means assuming a certain amount of risk, including the risk of HIV infection.

The definition of an eligible man may vary widely among African American women. While some may defined him as a monogamous, responsible man, others may think that ex-convicts and imprisoned men are eligible mates. The general consensus may be that any woman involved with a trustworthy "real man" is not vulnerable to HIV infection.

Local AIDS situation

The local population most likely to be diagnosed with HIV is African American women of child-bearing age. When these women become ill, grandparents often may be called to care for the patients' children.

Most African Americans who participated in this study had little knowledge about the extent of AIDS infection in Gainesville or Alachua County, saying that health officials have failed to inform them or that the statistics are not presented in the mass media. Although a few adults perceived AIDS to be an urgent problem in the black

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community, many appear to lack the motivation to seek AIDS information because they lack awareness of the local epidemic.

Those who have had personal contact with a person living with AIDS (PLWA) may be more likely to believe that AIDS is a local problem. However, PLWAs may tend to hide their diagnosis or label their illness as another disease. Although many believe that the virus soon will directly affect every African American family, AIDS has not yet hit close to home for most. The average education of African American residents is higher in Gainesville than it is among those living in many other cities, because of the presence of a large university. However, many perceive they are insulated from AIDS and that widespread transmission of the disease is limited to larger metropolitan areas. The absence of visible AIDS advocacy groups in Gainesville may contribute to this perception.

Despite the lack of public information about local AIDS incidence, some believe the disease is spreading rampantly and out of control, particularly among teens. Like many urban centers around the U.S., Gainesville's African American community has problems with prostitution, drug trafficking, and youth living on the streets. The city's police department does not have enough officers to curb these activities, even in neighborhoods just a few blocks from the University of Florida. Further, many African American prostitutes face a double risk of becoming HIV infection because they sell sex for drugs.

Because of high truancy among African American youth, many teens may not learn about AIDS except from their friends on the streets. Eventually, some are sent to juvenile detention centers, while other dropouts enroll in the Job Corps, which provides

job training and academic classes. Teens who enroll in the Job Corps live in dormitories, and these living arrangements may create conditions for the rapid spread of HIV. Despite the increased risk of transmission among youth in juvenile detention or the Job Corps, however, these institutions may provide an ideal place to initiate AIDS education efforts among African American youth.

Community AIDS prevention resources

The African American AIDS Task Force was founded by a cadre of respected African American leaders, with the intent of developing culturally sensitive AIDS prevention initiatives. After the first two years, some leaders still expected the group's internal momentum and publicity efforts to empower the black community to achieve various initiatives planned by the task force.

While many individual members have invested extensive time and effort in developing these initiatives out of concern or compassion, this highly educated group as a whole largely may have failed to connect with the African American residents who have the greatest need or risk. For example, a woman who counsels many residents of low-income housing areas speculated that either the group is virtually unknown within these neighborhoods or that these residents do not perceive a need to become involved in the organization. While several task force members commended their group's prevention efforts, others accused the group of neglecting the needs of African Americans living with AIDS.

The task force also lacks a sense of how African Americans outside the group might respond to its initiatives. A possible explanation of this problem might be a

myopic definition of the black community, limited to the social networks, cultural background, and personal experiences of the group's own members.

Specific gaps in connectedness between task force members and other black community residents also could be evidence of a kind of sub-cultural ethnocentrism, rooted in social distance between the haves and have nots. Suggested approaches to narrowing these gaps would be to involve youth, church leaders, African American adults from low-income housing areas, PLWAs, and members of other ethnic minority groups to participate in the group's planning, decision making, peer education, and the development of public service announcements and other new materials.
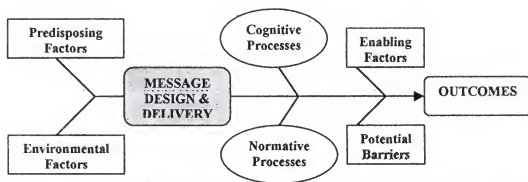
FIGURE 26: Message Design and Delivery in AIDS Prevention

Message design and delivery

Abstinence message

The lessons taught in middle school about abstinence and safer sex seemed to influence the sexual attitudes of many teens. The motives for practicing abstinence varied among individuals, but an individual's rationale often seemed to be gender related.

Many girls wanted to avoid the practical consequences of early pregnancy, such as the burdens of parenting responsibilities, no time to do fun activities with friends, loss

of a childhood experience, and the necessity of getting a job before completing an education.

Other girls feared emotional consequences, such as the hurt caused by lack of a partner's commitment to the relationship or to parenting a baby. In reflecting on the sexual decision-making that they use to protect themselves emotionally, some girls simply argued that "readiness" and a partner's respect of the timing of this readiness are the only rational requirements for having sex. However, the concept of readiness and how it protects a person's emotional well being was not clearly defined.

Most girls supported sexual abstinence as the most effective way to avoid HIV infection, although most believed they should be prepared to use protection. This finding is consistent with a study by Olsen (1992), which reported that girls who are junior high age or younger and teens who are virgins or naive about sex tend to rate abstinence-based sex education programs more highly than others.

Some girls and boys, however, considered the advice to postpone sexual involvement to be unrealistic. Further, abstinence-based HIV prevention advice may be doubted among youth who know that waiting to have sex does not necessarily prevent HIV transmission if one partner has been sexually active or has used contaminated needles in the past.

Many mothers complained that their abstinence advice to teens usually has gone "in one ear and out the other." However, some believed that teens' sexual decision making may be more rational in the late 1990s than it was among teens in the 1980s because most have participated in newer, more structured sex education programs that have increased their knowledge about consequences of unsafe behaviors.

Mothers believed a reason for abstinence is that teens should not value a partner more than their own health. Many Christian women argued that taking a public stand for abstinence is a religious duty and that voicing this position openly may encourage youth to seek guidance from them.

While sexual norms today may be less conservative than they were 20 or 30 years ago, many African American mothers fear that girls are too sexually aggressive and too easily persuaded to give in to a boy's sexual advances. While many women say they advise their children not to trust someone who is pressuring them, the pregnancy rate among church-going girls continues to rise.

Although teens are the primary target of abstinence messages, other unmarried African Americans are advised to follow the wait-until-marriage advice as well.

A parent who advocates abstinence but does not endorse safer sex often finds that teens lie or sneak out of the house at night, and their secret behaviors ultimately may be exposed by a medical diagnosis of a sexually transmitted disease or pregnancy.

While safer sex instruction tends to emphasize step-by-step condom use, traditional abstinence advice may be less efficacious because it tends to be more philosophical, abstract, and often does not emphasize practical steps or other specific skills. An over-emphasis on condom use among teens could be destructive in the long run, if it leads them to perceive that carrying a condom gives them the freedom to engage in sex with anyone without responsibly considering ethical or emotional issues first. When this attitude becomes a social norm among teens, it may encourage many to initiate sexual involvement much earlier than if they had valued their virginity. Further, it may

place a stigma upon virgins and upon the idea that virginity is a "special gift" to be saved for someone special.

While many African American ministers preach that sex outside marriage is taboo, some try to provide practical reasons for this advice, including such consequences as personal trauma, long-term frustration, a delayed or forfeited education, lack of mental or physical readiness, disease, or pregnancy. The benefits of abstinence, from a minister's perspective, include obedience to God, allowing God to satisfy needs and to provide empowerment to resist temptation, the inner peace of allowing God to select the best mate, learning to trust God rather than people with selfish motives, and the character building experience of trusting in God's timing rather than giving in to immediate gratification.

Conditional condom advice

Boys may fear the physical consequences of unprotected sex, but generally would not refuse an opportunity to have sex if they had a condom. Girls may be less likely to jump at the opportunity, and among church-going girls the belief that premarital sex is a sin can persuade them to postpone sexual involvement but tends to create an inner id-superego conflict.

Most African American ministers in Gainesville will not promote condom use from the pulpit because they fear it would condone premarital sex. However, a few of the more progressive churches may allow discussion of condom use with individuals in a less public setting. Compassion is the primary justification for this approach, whereas obedience is the primary justification of an abstinence-only approach.

Conditional condom advice may be morally defensible among those who believe that the church has a utilitarian obligation to help its weaker members avoid trouble by offering realistic alternatives to Biblical mandates. This approach is rooted in the communitarian ethic of strengthening the whole through offering universal validation and individual advice that is healthiest for each member of that whole. The strongest rationale for conditional condom advice, however, is the possibility that a person can suffer fatal consequences without protection.

Christians who have strong social ties with those who practice risky behaviors may be more likely to endorse this kind of dual message, particularly if they seek to emulate Jesus, whose ministry focused on outreach to prostitutes, beggars, lepers, and other social outcasts. Even many conservative Christians might view conditional condom advice as Biblically based if they viewed God as loving and forgiving, as opposed to just and punitive. If one believes that humans are morally frail and incapable of perfect compliance with God's laws, conditional condom advice would be defensible in light of the belief that God gives Christians the freedom to learn from their failures without having to pay for mistakes with their lives.

The flowchart on the following page, Figure 27, shows various outcomes that can result from abstinence and conditional condom advice in church settings. As shown by this study, the context of the AIDS prevention dialogue is critical because discreet advice can foster support while public discussion of controversial issues can lead to stigma, rejection, and public challenge to those who initiate such dialogue.
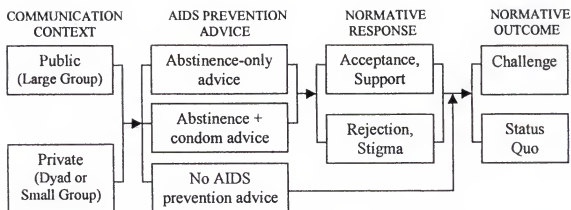
FIGURE 27: Normative Processes and Outcomes of AIDS Prevention Advice in Religious Contexts

The timing of AIDS prevention advice also may be critical. In order for youth to view the dual message as efficacious, they may need to hear it from a credible source before they begin to contemplate initiation of sexual involvement. By the time a teen's behavior arouses a parent's suspicion, the teen may not attend to a dual message, regardless of the source of that advice.

Source credibility

The oral tradition within the African American extended family strengthens the influence and credibility of the African American church because many older church members serve as moral teachers, initiating AIDS dialogue with adolescents within their biological family and other social networks. The oral tradition could be a key component of a church-based AIDS prevention intervention if it relied on church members initiating AIDS dialogue with others to share what they have experienced or learned.

African American ministers tend to have high credibility because church members expect them to provide guidelines for living. Parents also can have this kind of credibility with their children, but only when the child trusts them and respects their

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advice more than the advice they receive from competing sources. This finding is supported by Jensen (1994), who found that parents have a stronger influence on adolescents' sexual behavior than the media does.

In discussing sex or AIDS, however, some parents may be seen as less credible if they appear to lack knowledge, are overbearing or punitive, act suspicious or overreact to a teen's sexual behavior, or if they try to offer advice that is seen as incorrect because it conflicts with more credible advice from teachers or friends.

Many women and teens learned about AIDS by watching television public service announcements and programs featuring Magic Johnson, Arthur Ashe, Ezy-E, and other minority celebrities living with AIDS. Based on comments from focus group participants, recommendations for future PSAs include using more African American teens as peer sources because young audiences can identify with them, using credible rap stars or African American sports celebrities like Scotty Pippin and Michael Jordan because they are heroes, and avoiding the use of celebrities like Dennis Rodman who may set a bad example.

Most still respect Magic Johnson as a spokesman because of his decision to withdraw from the basketball team and because he has returned to the black community to speak to youngsters in schools. However, some African Americans do not identify with him and view his lifestyle as both his downfall and salvation – his celebrity-style promiscuity that led to HIV infection, and his wealth, which pays for medical treatments that would be financially out of reach for most other HIV-positive African Americans.

In a study of preteens' perceptions of AIDS before and after Johnson's announcement, Whalen (1994) found that the announcement increased perceived

vulnerability of self and others, but only among girls. This pattern was reflected in the comments of focus group participants in this study, as girls thought about how Johnson's situation might apply to themselves but the boys did not appear to contemplate this.

The youth targeted by the fotonovela intervention received AIDS prevention advice from the voices and viewpoints of their peers—visually, orally, and in writing— rather than from experts, teachers, parents, or other adults. Overall, teens appeared to view peer sources as more credible and persuasive than adult sources. Some teens said their peers rebel against advice given by unfamiliar adults about AIDS prevention, or any other topic for that matter.

Cultural relevance

AIDS prevention campaigns were criticized for failing to effectively target African Americans. Primary reasons given for this failure are that campaigns are developed by and for whites and do not use street language, African American slang, or other Ebonics. Other recommendations for future AIDS prevention campaigns targeting African Americans include an emphasis on unconditional love and tailoring a message to address stigma among African Americans toward homosexuals, PLWAs, drug users, and others within the black community.

Various AIDS prevention campaigns targeting African American youth should be tailored to address culturally specific aspects of sex-role socialization, decision-making processes, family norms, views of marriage and parenthood, racial identity, common communication styles, heterosexual relationship norms, homophobia, gender rules, empowerment, and feelings of self-efficacy.

African American teens are likely to find a *fotonovela* more appealing if it makes sense to them by lining up with their own cultural experiences.

Given possible differences in mass media use, such as different preferences for romance novels, teen magazines, or rap music, girls tended to prefer a dramatic presentation of AIDS prevention advice, while boys preferred a more factual and comprehensive presentation. In developing the *fotonovela*, more of the girls volunteered to write and participate in skits, while boys preferred to write and participate in raps.

Girls also composed simple, repetitive, unaccompanied songs that contained an AIDS prevention message. Another popular activity among African American girls that was incorporated in the *fotonovela* was the choreography of "step shows." These dance performances provided excellent photo opportunities. When African American youth performed a step show, they coordinated clapping, shuffling, stomping, or other dancing in circles or lines, and coordinated these rhythmic movements with recorded music, raps, or simple *a cappella* songs.

The use of raps in a *fotonovela* was particularly attractive among African American teens because the booklet offered a written version of raps in a culture where raps are usually shared and taught orally. These simple raps enabled even inexperienced rappers to impress their friends. The boys from lower socio-economic backgrounds appeared to prefer rap writing over skit writing more than the boys from higher SES backgrounds. This may have been the case either because street culture is less prevalent in higher-income neighborhoods or because skit writing is perceived as a more difficult or less enjoyable task among boys from lower-literacy homes.

Some aspects of the *fotonovela*, such as raps, slogans, or slang, were not intended to be humorous but nevertheless were seen as funny. Other youth felt that AIDS is no joking matter, and they expected their friends to treat the issue seriously when they presented a *fotonovela* for discussion.

Suggested messages

Among women, suggested messages for future AIDS prevention campaigns targeting African Americans warned others to be careful in selecting a sexual partner, fostered a desire for learning more about AIDS, promoted HIV testing prior to sexual involvement, confronted denial, advised constant protection, warned others not to trust another's word about being clean, warned others not to take even one chance, reminded others not to take anything for granted, and advised others not to be blinded by love.

Messages suggested by youth advised teens to keep their pants zipped or shirts down, to be careful, to watch others to see if they are promiscuous, to avoid sexual involvement with strangers, to always use condoms, to wait until marriage to have sex, and to be prepared to use a condom in the event that a tempting situation unexpectedly pops up.

Visual appeal

While the 8.5 by 2.8-inch, tri-fold *fotonovela* appeared to be a preferred size among girls and women, some boys preferred a larger-sized booklet with more pages of information and accompanying illustrations to complement the drama. While girls preferred a relatively small type size for the story script, a slightly larger type size for raps, and a comic book-style font for the lettering within a *fotonovela*, boys wanted the title and major headings or messages to be more stylish and less traditional.

While the use of spot color or color photographs in a *fotonovela* was preferred by teens, it was likely that color would have made the publication more attention getting and memorable. At the time this study was published, a revised version of the *fotonovela* which included red spot color was being considered by the African American AIDS Task Force for inclusion in the public school health curriculum and for distribution at various tabling events.

Photographs appeared to play a more important role than text in stimulating conversation between the *fotonovela* presenter and recipient. Girls particularly liked the look of *fotonovela* photographs that were considered humorous or realistic. Boys, on the other hand, tended to prefer photos that depicted "forbidden" sex-related objects such as condoms or adult videos. These kinds of photos not only attracted more attention, but they also served as a memorable, visual prevention message by showing both physically and symbolically the necessary tools for protection within a sexual context.

Boys preferred photographs that showed action, exciting situations, and specific behaviors that can lead to HIV transmission. Photos showing African American boys playing basketball served as important cues to promote cultural identification, given that a common dream among many African American boys is stardom in the National Basketball Association and that many girls admire athletes.

Among teens, girls appeared to be more self-conscious about whether they looked physically attractive in photos, while boys tended to worry more about whether they were portrayed as romantically interested in girls. Some youth were concerned about sexual dialogue being linked to their photos, particularly if they believed a parent might jump to the conclusion that the situations described in the story had actually happened.

The photographs in a *fotonovela* may lead some teens to perceive it as less informative than a traditional AIDS prevention brochure. The presence of more photographs may cause some to perceive it as having fewer statistics and direct prevention advice. The actual number of facts and overt advice messages in a *fotonovela* may be the same or greater than the number within many traditional brochures. In the interest of devoting sufficient space to the story, a *fotonovela* may not contain the typical step-by-step condom use instructions seen in many other AIDS prevention materials.

Preferred channels

Among African American youth, the preferred channels for AIDS campaigns targeting African American youth included television and radio PSAs, educational films, movies, cartoons, and dramatic television mini-series. Another suggested channel for dissemination of AIDS information was HIV testing. Women tended to prefer visual media, particularly videos or photography that depict the effects and stages of AIDS. Campaign devices that youth found memorable included the use of statistics at the end of a PSA or video, as well as the use of a slogan recited by the dramatic cast of a video or television program.

The awareness of tools and strategies used in traditional AIDS prevention campaigns prompted some individuals to favorably contrast the *fotonovela* with past approaches. This evaluation may have been rooted in their desire for a fresh approach to AIDS prevention and their hopes that a *fotonovela* intervention might be more a more effective strategy than past efforts. Many also saw the *fotonovela* as more attention getting than other AIDS campaign materials because it was collaboratively created by and for teens.
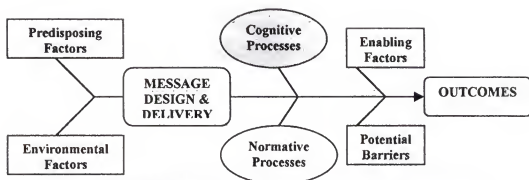
FIGURE 28: Cognitive Processes in AIDS prevention

Cognitive processes

Comprehension

African American teens may be more likely to find a *fotonovela* easy to read if they perceive it to be simple, if it does not include more material than they can read in a few minutes, and if the grade level of the reading is below the level of materials they must read for school. Teens who lack sufficient reading skills and other low-literacy individuals may better understand the key messages in a *fotonovela* than in a traditional AIDS prevention brochure, since a *fotonovela* contains photographs that can provide cues about the story line and its meaning.

Younger teens appeared to require an overt advice message more than older teens did. Even youth who were more interested in looking at the photos than reading the script or AIDS prevention advice appeared to understand the *fotonovela*'s message, perhaps because they could contextualize their visual impressions within an AIDS-related schema.

Girls may have better understood the dual message of abstinence and safer sex than boys. Boys tended to frame any AIDS prevention message as safer sex advice, even

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when the actual messages emphasized abstinence. Boys also were more likely than girls to talk about AIDS or sex as part of a conversation about a *fotonovela*, and conversations among boys tended to focus on condom use more than other topics. This indicated that the behavioral impact of a *fotonovela* might be enhanced if teens were given condoms to hand out with the booklets.

Learning about prevention

When people are aware of everyday health risks other than HIV infection risks, they tend to be more likely to attend to AIDS prevention messages as well. Even when African American youths are attentive to abstinence advice and knowledgeable about the consequences of sex, they may not follow this advice because they must learn from their mistakes.

Many youths may not contemplate verbal advice, including AIDS prevention advice. The stimulation of attention, involvement, and learning may partly depend upon the use of visual media, such as photos, videos, or cartoons. When media show, rather than simply tell, audiences may be more likely to remember the message.

The tendency to attend to the visual presentation of a message may partly depend upon an individual's learning style. While some individuals tend to learn most effectively from visual presentation of material, others may learn best from an auditory or hands-on presentation. Although visually and realistically showing how a person could become infected could be disturbing to some, it may be the most effective educational strategy.

Sexual scripting

Boys believed they were expected to initiate sexual activity with girls, to provide protection such as condoms, and they realized that their advances may be seen as harassment. Rape is perceived as a particular problem and risk factor among African American men. Most boys would sexually push a girl as far as she would let him, and one even bragged that he would initiate immediate sex with any woman who gave him permission. Most would jump at the chance to sleep with an attractive woman.

While boys want to engage in sex with their girlfriends as early as possible in a relationship, they do not want to risk alienating the girl by pressuring her too much. Girls generally do not want to engage in sex, even after involvement with a boy for several months. Girls place a high value on getting to know a boy before becoming intimate with him.

Although most boys feel they are now ready to initiate sexual involvement, they still listed many reasons for justifying that readiness: when they are in love, when they are willing to accept responsibility for a possible pregnancy, when it meets their needs, when it is common sense, when it is just a stage, or when they get married.

Even boys who believed a person should wait until marriage to have sex were not confident in their own ability to comply with that standard. Although none admitted to being virgins, many believed they would someday find themselves in a sexual encounter they could not anticipate or escape. The belief that a person cannot get out of a sexual encounter, because of the actual or perceived influence of drugs, alcohol, or physical drives, reflects a lack of self-efficacy.

The traditional sexual script for adolescent boys may be to pursue sexual relations at every opportunity. Although the sexual norm may be for boys to initiate sexual involvement with girls, the girls often may be the aggressors. While boys are not expected to resist pressure to have sex, a boy may feel that a girl's advances are a threat to his sense of masculine control. If a girl pursued them, some boys would withdraw from the encounter and hide or escape to avoid her advances, while others would try to control the sexual boundaries and the extent of physical involvement.

Many non-Christian African American men and women may "try" a Christian to see if they can persuade their religious friend give in to their sexual advances. Even non-Christian women, however, may expect a minimal level of commitment in a relationship before having sex.

Religious African Americans may be more likely to view television as a bad influence that encourages people to engage in adultery and fornication.

Health beliefs

Perceived susceptibility: Lack of perceived susceptibility could be a more powerful predictor of risky behavior than a lifestyle considered "immoral," lack of conscience, or irrational thought.

Perceptions of susceptibility among boys may be linked to beliefs that AIDS is a local problem, that anyone is vulnerable to infection, and that black teens are susceptible. A person's lack of perceived susceptibility may be tied to beliefs that local PLWAs are only prostitutes, bums, ugly men, social outcasts, or people who are careless or immoral, as well as the belief that no one in his or her own social network is susceptible to infection.

Even when African American teens may be concerned about others and believe that other teens should be more concerned than they are, they may not worry about themselves. Perceived susceptibility about self or others may be mediated by an individual's perception of how close to home AIDS is hitting. It also may be influenced by how concerned peers appear to be.

Even when they were personally concerned about AIDS, most teens believed they themselves would never become infected. The few who did believe they were vulnerable expressed fear of dying, fear of illness, or a need to learn more about the disease.

Married women may be less likely than teens to feel personally susceptible, particularly those who believe they already have an adequate amount of knowledge about AIDS. This finding highlights a need to target African American women involved in monogamous relationships with an AIDS prevention message emphasizing their potential risk factors and dispelling the myth that only single or promiscuous people are at risk of HIV infection.

Perceived threat: African Americans in mid-sized cities like Gainesville may not view AIDS as a salient issue if they believe the disease does not pose an immediate threat or that few people within their social networks have been infected. In larger cities, where high rates of transmission may be concentrated in certain neighborhoods, more members of an individual's social network might be affected, thus increasing the odds that infected individuals might disclose their HIV status to others.

Perceived threat may be associated with an individual's career-related or personal connection to a local health care system, as people linked to this professional network may hear about more incidents of HIV infection or AIDS deaths. If this connection is a

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predictor of perceived threat, it may be particularly common in smaller cities where there are fewer channels through which local AIDS facts actually flow.

The belief that AIDS will continue to spread may increase perceived threat. The extent that church members perceive AIDS as a threat may be associated with whether their minister has personally counseled with a person living with AIDS (PLWA). Individuals who are highly involved in church activities may be more likely to depend on church-centered social networks for interpersonal information exchange. If this is true, these individuals would be expected to have lower perceived threat, given that African American churches are less likely than the general black community to discuss AIDS in any context.

Perceived threat may be lower among African Americans who believe that most people with AIDS are gay white men. Given that this stereotype was created by news media in the 1980s, this belief may be more common among African American adults than among youth.

The use of AIDS euphemisms such as "long illness" would be expected to lower perceptions of threat among individuals who do not understand that an AIDS diagnosis is being veiled because they would have more difficulty ascertaining how widespread HIV infection is within in their own community.

Perceived severity: Even individuals who know that AIDS is fatal may not understand or contemplate the years of suffering that most AIDS patients must endure. Thus, an individual's understanding of the fatal consequences of infection may not be sufficient for the person to fully understand the severity of the disease.

In addition to believing they are invincible, many teens may believe they have the freedom to learn from their mistakes as their parents may have done. They may not believe they live in a different society where one mistake could end their lives.

Framing sexual abstinence or safer sex advice often may be useful for the prevention of both HIV infection and pregnancy, especially for teens who fear the consequences of an unwanted pregnancy more than the consequences of AIDS. However, when a message presents dual consequences for the same behavior – death from AIDS and inconvenience from pregnancy -- some teens may view AIDS as less severe than if the message did not include pregnancy as a consequence of unprotected sex. This tendency might be particularly true for African American girls who want to conceive a child before marriage and would not feel stigmatized by being an unwed mother.

Although neither a cure nor effective vaccine for AIDS has been discovered, publicity about new AIDS treatments such as "the cocktail" may lower the perceived severity of the disease among many people, particularly among risk takers.

Perceived benefits of practicing abstinence: The health belief model posits that an individual weighs costs and benefits before deciding whether to comply with health advice. The perceived benefits may need to offset the costs or barriers before compliance can occur. This study proposes the postponement of sexual involvement as a recommended AIDS prevention strategy because this advice is acceptable and salient within the social networks that are linked to church-going opinion leaders. In order for this advice to be taken seriously by teens, however, they must first perceive benefits that outweigh costs.

Among both boys and girls, the benefits of abstinence included disease prevention, financial support for a child, and the opportunity to advance their education. Mothers, on the other hand, perceived that a major benefit for a girl is keeping her status as a virgin because after just one sexual encounter, a girl cannot reclaim her virginity. The extent that girls view virginity as prerequisite for higher status, purity, or self-esteem may predict the extent that they are willing to comply with abstinence advice.

For many Christians, a primary reason to abstain is to avoid the eternal damnation believed to be the final punishment for sin. Thus, the extent that a person believes in Hell or an afterlife might predict their willingness to practice abstinence.

Perceived consequences of sexual involvement: Although postponement of sexual involvement is the recommended behavior, the perceived consequences of non-compliance besides HIV infection could be more predictive of compliance. One perceived consequence of sex was emotional pain, including shame, rejection, depression, loneliness, and feelings of victimization. Other perceived consequences are unwanted pregnancy and sexually transmitted diseases, and these problems are believed to occur even among teens who use condoms. Boys feared the consequences of a sullied or broken relationship, such as jealousy, worry, paternity suits, child support, rape accusations, and the inability to restore a relationship to the way it was before sex.

Sexual revenge attitude: The idea that an HIV-positive woman should seek revenge by infecting other men as restitution for her plight may be a widespread attitude among African American women. Among the women in the focus groups, the perception that many other women believe this way was frequently mentioned but condemned. An African American woman might be motivated to seek this kind of revenge because she

has lost her conscience or has been emotionally hurt by men, has felt deceived by an unfaithful partner, or because she wants others to die along with her.

Among African American males, a woman's sexual revenge is hated and feared, and many may inherently believe that women are generally untrustworthy, manipulative, selfish, and vengeful.

Motives for risky behavior: Among those who view premarital sex as wrong, a motive for engaging in risky sex may be to accomplish a kind of moral purging -- to get the sin out of their system once and for all, so that they can live the rest of their lives in compliance with their own moral standards. Boys may be more likely than girls to engage in sex to satisfy a need for physical gratification.

Curiosity, especially the desire to have a new experience, may be a key motive for sexual involvement among teens. The desire for fun and excitement may be another motive. Those who are more emotionally involved or mature may seek intimacy in the experience. Other motives for sexual involvement may include irrational impulse, a desire for love or acceptance, revenge against a parent, or desire to please an attractive boy.

In the black community, AIDS prevention efforts may be more effective if they begin at the grassroots level and then branch out through various social networks.

In a community where no AIDS ministry, education, or outreach efforts have been conducted within African American churches, radical changes in religious and
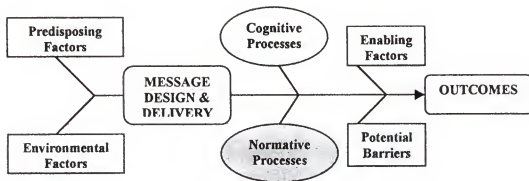
FIGURE 29: Normative Processes in AIDS Prevention

institutional norms may need to occur before an AIDS prevention "innovation" can be introduced. An African American church may fail to initiate AIDS discussion if its opinion leaders do not perceive a need for this dialogue.

Normative processes

A diffusion model of church-based AIDS dialogue

If no one ever admitted that they or their family members were affected by AIDS, most church members would likely perceive that AIDS is not a problem within their congregation and that it does not need to be addressed.

The likelihood that a church initiates an AIDS prevention program may depend upon whether a person in its congregation admitted having the disease. The change agent for an AIDS prevention innovation in black churches may need to be a person or group that has the same ethnic and religious background as the churches

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targeted for intervention. Given that social service agencies and volunteer AIDS organizations tend to consist of individuals from varied religious, professional, socioeconomic and ethnic backgrounds, it is questionable whether such a group, as a whole, would be the most appropriate change agent to directly initiate church-based interventions. While these kinds of organizations may have needed resources and credibility within the black community, a lack of homophily between their values and those of ministers could block any inroads the organization might try to forge into targeted churches.

A more appropriate change agent might be a flagship church whose key opinion leaders receive AIDS educator training and other assistance from an established community-based AIDS prevention agency. Once the flagship church has established an AIDS ministry, it could target innovators in other churches who could serve as peer educators and serve as liaisons between the flagship church and members of targeted churches. Given that ministers may fear political reprisals for publicly discussing controversial issues associated with AIDS prevention, the most appropriate innovators may be lay leaders, such as deacons, deaconesses, youth leaders, and Sunday school teachers. This study suggests that female opinion leaders might be much more involved and effective innovators than male leaders.

A change agent may increase the likelihood of success in launching an AIDS ministry by locating a key person or small group who is deeply concerned about the vulnerability of church members and who is willing to talk to others about issues that are part of an intervention agenda. A strategy for reaching that person or group might be for the change agent to schedule a guest speaker or workshop leader to address as many

members of the targeted congregation as possible with a non-controversial message promoting AIDS awareness and compassion. This event would be expected to draw out the most interested individuals who could form a core group of innovators.

These innovators would be encouraged to engage in conversations that promote AIDS awareness and dialogue among friends and family within their social networks. As the innovators "spread the word" to various members of their church, more members would accept and adopt the same behavior and continue to infiltrate their individual networks with AIDS-related dialogue. Eventually, most members of the targeted church would reach a consensus that either asserts that talking about AIDS is beneficial or that it is unnecessary or potentially harmful. Even if the consensus is negative, the AIDS dialogue might continue to spread through a multitude of other social networks outside the targeted church, depending the types of social ties that each innovator or adopter has within the larger community.

Network diffusion of AIDS information through interpersonal dialogue ultimately may be more effective in changing community norms, as compared with mass mediated campaigns that emphasize individual behavior change. The "word of mouth" strategy not only promotes dialogue within organizations and institutions, but also may promote more intensive dialogue between individuals who are actively involved in various kinds of personal community outreach and among the weak or non-existent ties within their social networks.

Popular norms

The *fotonovela* intervention relied upon popular norms to help build momentum among the participants. The perception that peers are successfully sharing the *fotonovela* with others could have increased a person's perceived self-efficacy to do the same.

Among African American boys, a barrier to sharing a *fotonovela* with friends appeared to be a cultural norm of macho indifference. In their attempts to appear "cool," boys may have been trying to avoid looking excited or eager to share a *fotonovela* with friends. In addition, they may have perceived that giving advice to other boys is not "cool."

Boys who bragged about having sex or tried to give others the false impression that they are sexually active may have done so to show that they are complying with popular norms among their peers. Girls perceived that their dress is a reflection of their sexual behavior or standards. Those who wear revealing clothing may be negatively labeled as promiscuous "hoochies," while those who wear baggy clothing may be seen as virgins. Some African American boys may pull their shorts down until they expose their butt, but the sexual connotation of this fad is not clear.

Girls generally perceived boys as less mature than they themselves are, particularly in discussing sexuality issues. However, most boys held the same view and believed that girls were less impulsive and more thoughtful about sexual decisions.

Sex-related popular norms among African American teens appear to vary by age. Older teens may perceive that their peers are sexually active, but handling these relations responsibly, while younger teens may perceive that having sex is a rite of passage into adulthood that must be accomplished as early as possible to avoid the stigma of virginity.

Younger teens also may perceive that the opportunity to have sex with an attractive partner should not be refused. Teens also perceive that their peers are savvy or "not stupid" about practicing safer sex.

Women may perceive that they are less likely than teens to become HIV infected if they see themselves as more alert and concerned about personal health. However, both women and teens perceive that infidelity among African Americans is commonplace.

Prescriptive norms

Taking personal responsibility to halt the spread of the disease by practicing safer sex may be a prescriptive norm among African Americans. Another prescriptive norm may be that a couple should not become physically intimate if either of them is already involved with another person, and each person should ask the other about outside involvements if the information is not volunteered. Casual sex with strangers is considered irresponsible, and couples should get an HIV test before entering into marriage or sexual involvement.

Girls were more likely than boys to express feelings of embarrassment about sexual content or sex talk. Girls also were more concerned than boys that they should appear to comply with prescriptive norms of sexual behavior. This difference could be rooted in the traditional double standard that endorses sexual experience among males while punishing females for the same behavior. Ironically, boys were more likely than girls to believe that girls should be taught abstinence before they become sexually involved. Again, this could reflect a double standard.

While it may be easy for married adults to criticize young people who are struggling with sexual dilemmas, and while many African American adults conceive and

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raise children out of wedlock, marriage is still a prescriptive norm among African Americans of all ages. People should marry in order to raise children or to cement an emotional commitment.

Prescriptive norms for African American ministers, as defined by teens, are different from those applied to other adults. Ministers are expected to hold attitudes and use particular counseling approaches appropriate and conducive to open, helpful dialogue. A minister is supposed to think and communicate on the same level as teens, except that he also is expected to dole out moral or spiritual advice. Girls expect ministers to refrain from cursing, and they expect a minister's counseling demeanor to be gentle and empathetic, not forceful or confrontational.

Peer pressure

African American males may become promiscuous or have a one-night stand in order to prove their masculinity to peers. Among boys, gaining the respect of friends or saving face may be other motives for initiating sexual involvement, bragging about conquests, or pretending to be sexually experienced. These findings are consistent with those reported by Jensen (1994), who found that among high school students more boys than girls reported societal pressure to become sexually active.

Girls may be more likely to give in to sexual pressure from a boy if he plays football or basketball if involvement in these sports gives him higher social status and peer respect. The acquisition of status symbols, such as brand-name tennis shoes or clothing, is another form of peer pressure among teens.

Boys may be more likely than girls to have casual sex because of pressure from their male peers. Among girls, however, sexual pressure from a boyfriend may influence

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a teen's decision to have sex more than pressure from other peers. Even so, a teen may lack the self-confidence to approach an attractive boy or girl unless peers first provide encouragement. The thrill of being "singled out" by an attractive person in the presence of peers could create a risky situation if the teen were more likely to give in to the seduction or pursue the person in order to impress friends.

Many teens may drink because they want to prove to their group that they are "cool." Some teens believe that refusing to comply with peers is difficult but not impossible. A teen who is capable of maintaining this individuality may believe that her friends lack understanding of her needs or that her decisions about romantic relationships, drinking, and other matters are private. Individual personality differences may better predict how teens respond to peer pressure than gender or age differences.

While the desire to be seen as an adult may motivate many teens to succumb to peer pressure, this same motive could be used to develop an AIDS prevention message that emphasizes maturity, responsibility, and independent thinking as adult traits.

Church influence

Socialization in the church may help reinforce prevention advice among youth. This socialization may include exposure to sermons about sexual issues, Sunday school discussions or youth programs that address romantic and parent-child relationships.

Church may be an ideal setting to help teens and parents learn to communicate with each other because small group discussion can foster exploration of personal issues, promote open dialogue, and offer skills training.

Most churches teach Scriptural justifications for abstinence and spiritual consequences of sexual sin that can serve as moral standards for behavior, particularly for

those who believe they should maintain a personal relationship with God. Without these standards and a social network of Christians to provide moral accountability, African American teens might lack a reason to practice abstinence.

Even boys who know the church condemns premarital sex and who personally believe it is wrong may not understand why the church teaches this. Talking about sex in church does not always discourage religious teens from having sex, and their Christian upbringing may not ultimately prevent their exposure to HIV. A teen who knowingly commits sexual sin may view the act as reprehensible but rationalize it through social comparison and other cognitive strategies.

Church attendance and involvement in other organized religious activities could help a Christian maintain a healthy lifestyle and reinforce lasting behavior change, particularly if ministers present practical, Bible-based advice that appeals to a Christian's desire to attain a lifestyle pleasing to God.

Figure 30 on the following page is a Baysian diagram highlighting the various behavioral outcomes of abstinence and condom advice targeting single individuals in a religious context. The model also includes common labels assigned to individuals, based on their compliance or lack of compliance with religious advice about sexual behavior.

Parental influence

Although abstinence advice is often presented or reinforced in church, boys may be more likely than girls to get most of this advice from their parents. This finding is consistent with a study by Jensen (1994), who found that more than twice as many high school girls as boys reported that friends encouraged abstinence, while the primary source of abstinence encouragement for boys was their mother or father. While mothers

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may offer much of this advice, most boys prefer to talk to their fathers about sexual issues. This preference appears to be based on perceived differences in communication style, not gender.

Deliberate Abstinence (Good Christian) → *Periodic abstinence* → Will revert → **Sex with condom** ↔ **Always** / Sometimes / Never; → Sex without condom

Deliberate Abstinence (Good Christian) → *Virgin (The Pure)* → *Never reverts (The Faithful)*

Incidental Abstinence (Lukewarm Christian) → Occasional sex (Abstinence not deliberate) → **Sex with condom** ↔ **Always** / Sometimes; → Sex without condom

Non-Abstinent (Sinner) → No attempt to abstain from sex → **Sex with condom** ↔ **Always** / Sometimes / Never; → Sex without condom

Boldface = AIDS preventive behavior in compliance with condom advice
Italics = AIDS preventive behavior in compliance with abstinence advice

**FIGURE 30: Behavioral Outcomes of Abstinence and Condom Advice
for Single Individuals, in a Religious Context**

Boys may perceive their fathers or other father figures as more knowledgeable, experienced, unpretentious, open, understanding, and willing to listen as compared with their mothers who may be seen as fussy or old-fashioned. Boys may regard their fathers as the most credible source of advice, among all sources, even though fathers may be seen as too old to relate to the pressures and uncertainties that youth face. Boys who do not feel close to their fathers may seek sex advice from siblings, friends, romantic partners, or a telephone hotline.

Girls may be more likely than boys to prefer to talk to their mother or a grandmother about sexual issues. Although many women believe open discussion about

sex with their pre-teen children is important, it is unclear how often this kind of mother-child discussion actually happens. The likelihood that a child will initiate a conversation with a parent may depend on the extent that he or she is extroverted.

Whalen (1996) found that in response to parent-child dialogue about AIDS, girls were more mutual and expressive than boys, while boys were more withdrawn. Stigmatizing attitudes among teens were associated with low levels of parent-child dialogue about AIDS, as well as with low levels of social support from parents during AIDS discussions.

Parents who use a directive approach to sexual dialogue may be more likely to establish firm rules for behavior than parents who use a mutual approach. Establishing rules, however, may be more effective than mutual conversation in helping younger teens develop long-term decision making skills and independent thought. Role-playing may be a common mutual approach, and this strategy may be a more effective means of discussing difficult issues, particularly if the parent plays the role of a peer.

The advice to "watch for the signs" may be an effective strategy for parents to detect subtle evidence that their child is engaging in risky behavior or may feel trapped by peer pressure. This strategy could be promoted through a community campaign targeting African American parents, particularly the highly religious. Similar campaigns in the past have alerted parents to signs of drug abuse, alcoholism, or learning disabilities. An AIDS prevention "watch for the signs" campaign could emphasize listening skills and maintaining an open line of communication with teens, as well as show how "good" teens from strict families may secretly engage in forbidden behavior.
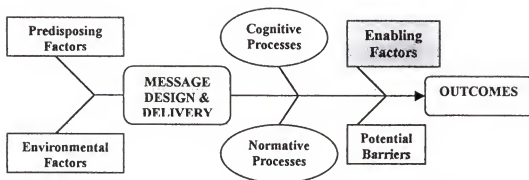
FIGURE 31: Enabling Factors in AIDS Prevention

Enabling factors

Self-efficacy and response efficacy

Among African Americans who have substance abuse addiction or risky sexual habits, hopelessness -- a severe lack of self-efficacy -- may be a major barrier to overcoming these habits. To promote self-efficacy among youth, adults may need to take control of their own lives, to show that they have the courage to rise above perceived popular norms to follow through with AIDS prevention advice.

Girls expressed higher self-control beliefs than boys, a finding consistent with Stevenson's (1995) study of HIV beliefs among African American teens. Among low-income African American adolescents, Reitman (1996) found that lower self-efficacy in using condoms was associated with high-risk behavior. Given that many youth focus group participants believed that abstinence is "correct" sexual behavior yet have low perceived self-control, AIDS prevention initiatives targeting this population should promote the dual message of abstinence and conditional condom advice.

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A lack of response efficacy, including lack of confidence in marriage and condom use as HIV prevention methods, could be a major barrier to effective AIDS prevention. To promote response efficacy, an AIDS prevention campaign or intervention may need to emphasize the idea that gaining knowledge and awareness can help prevent HIV infection, that talking openly about AIDS issues is an effective prevention strategy, and that both sexual abstinence and safer sex methods can be protective if they are practiced consistently.

Modeling

The awareness of potential "slip ups" can be learned through seeing consequences of others' mistakes and can lead individuals to reflect on situations that could lead to a fatal mistake in their own lives. This kind of modeling may be most effective when presented in a video or other visual format. Among girls, homophilous style of dress and age may be critical characteristics for characters in an AIDS prevention drama.

Using respected leaders such as ministers as role models could be precarious given that they may eventually engage in behavior that is seen as hypocritical. In the context of a dramatic prevention message, portraying a character whose behavior is risky as attractive could confound the intended outcome of a prevention message if audience members were compelled to imitate the actions of a seductive or otherwise socially desirable person. While the attractiveness of characters may be essential in promoting identification, the construction of a story line must carefully consider which attitudes and behaviors will be seen as desirable, both from a health promotion perspective and in light of social norms. In the *fotonovela* story line, for example, the boy who was pushing for

sexual involvement was portrayed as a high status, attractive person whose attitudes about sex were depicted as immature, "not cool," and naive.

Heritage reminding

Reminding youth about their African American heritage, particularly their religious heritage, could be a strategy for promoting AIDS prevention. Appealing to ancestral pride may promote in-group identification, which could be more influential in changing attitudes and behavior than popular norms, if presented in a persuasive format.

The extent that churches now transmit the religious values developed by African slaves is not clear. However, historical stories about slaves' faith in God during their struggles for freedom could show African American teens how to cope with difficult situations in their own lives. These coping strategies might include private prayer as a way of allowing God to show them an escape from adversity, public worship as a means of emotional catharsis and spiritual connection to others and God, and spiritual songs that can provide intellectual identification with slave roots and the quest for freedom, as well as an introspective awareness of everyday struggles.

Heritage reminding may be a tool for empowering teens to postpone sexual involvement or to otherwise protect themselves from HIV infection. An appeal to heritage sharing could promote the idea of mutual protection among those with common racial ties. A message emphasizing that black brothers and sisters should look out for one another could include advice to warn others about risks and to comfort those who suffer from the disease. The use of Swahili phrases or Kwanzaa themes may be an effective tool for heritage reminding.

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The girls' expressed interest in African American heritage and ethnic pride could be a key component of their search for identity. Lenaz (1991) found that the search for identity among many minority teens is a strong motivational factor in engaging in sexual intercourse at an early age and that the decision to postpone sexual involvement can be empowering and ego-enhancing for these teens.

Achievement orientation

Talking about future plans for success is a strategy adults could use to encourage teens to protect their health. Giving teens a vision for the future may help them make more rational decisions, possibly because they are motivated to protect these dreams or because their personal decisions could be clarified in the context of a long-term plan.

Helping African American teens combine career aspirations with ethnic heritage awareness may be an important strategy in motivating them to make rational and healthy lifestyle choices, including decisions to postpone sexual involvement or consistently practice safer sex. This combination approach may be critical given that Arroyo and Zigler (1995) found that academically successful African American adolescents often achieve their success by adopting behaviors and attitudes that distance themselves from their culture of origin, resulting in feelings of depression, anxiety, and identity confusion.

"Making it real"

AIDS prevention efforts may lack sufficient impact unless they show how people suffer from the disease. Meeting a PLWA in a school or hospital setting could be an effective way to show teens the seriousness and severity of the disease and to promote compassion toward PLWAs. Among various audiences targeted with AIDS prevention messages, African American teens may have a greater need to see evidence that others

like themselves are actually contracting the virus. The use of intense imagery or personal contact with AIDS patients may be an important not sufficient factor in persuading youth to practice AIDS preventive behaviors.

These strategies, however, could produce a counterproductive level of fear and could prompt criticism from parents who do not want their children to be physically exposed to an infected person. African Americans who have experienced the AIDS-related death of a loved one also could speak to youth about the disease, or ministers and other teachers could present true stories about people contracting AIDS, but it is not known whether these less direct strategies would be as effective as presenting the personal testimony of a PLWA.

Open dialogue

Open dialogue about AIDS may be more important than educational campaigns in sustaining healthy behavior patterns among African American teens. Church settings where comfortable dialogue might be promoted might include Sunday morning worship services, and small group discussions within Sunday school, Bible studies, or youth programs. Common strategies that parents may use to bring up the topic of AIDS prevention with teens might include talking about a news story or magazine article, school lessons, follow-up to an AIDS prevention presentation, aspects of the human body, Scriptures that address sexual issues, or personal relationships.

Boys may be more likely than girls to seek advice about AIDS or sex from friends or a romantic partner rather than a parent. These preferences also were reported by Jensen (1994), whose survey revealed that high school girls consider parents' feelings about sex more while boys rate the feelings of male peers or girlfriends higher.

Similarly, the fact that some girls remembered talking with their mothers about AIDS while boys did not discuss it with a parent was consistent with a study by Sly (1995), who found that mothers are more likely to talk to their daughters than their sons about AIDS even though sons and daughters are equally likely to ask their mother questions about AIDS.

Many youths may anticipate too much difficulty in initiating conversation about sexual issues with an adult. A barrier to the initiation of this kind of dialogue is a parent's reaction of shock or disapproval, which may be most likely when the teen's question concerns birth control.

Adults may be just as reluctant to initiate conversation about sex with teens because they expect the situation to be awkward. The willingness to suspend judgment and show acceptance may be prerequisites for effective parent-child conversation about sex. A barrier to open dialogue may be an adult's authoritarian lecturing or scolding, even though teens may expect and need the adult to provide a reason for behaving a certain way.

When an adult deliberately establishes and maintains a relationship with a teen, this open line of communication may play an important role in preventing the child from making serious mistakes. Identifying major communication styles among African American youth could help inform parents about how they must adapt to these differences. Talking about behavioral intentions with teens, while offering them unconditional acceptance, may be essential to an effective discussion about sexuality.

Sharing personal stories about the challenges of growing up is often an essential part of open adult-teen dialogue. An adult's honesty about past mistakes could help youth make sense of their own circumstances.

Many adult church members could serve as role models and as friends for youth. Role playing could help church members of all ages learn how to communicate with each other about AIDS prevention issues, so that children will not be naïve about these issues. Adults should be prepared to answer a child's sex-related questions at every stage of the child's development.

Communication skills training for parents could help address barriers to effective parent-child communication. A focus group could be used for a parenting workshop or a school-based discussion group for parents and their children, as this format could serve to promote thought, awareness, and continuing dialogue in a non-threatening setting. The moderated, semi-structured focus group also might be used within churches as an AIDS prevention tool because it could raise awareness, knowledge, and focus thought and discussion on individual concerns.

Empowerment

For a *fotonovela* intervention, the oral tradition could be used as a key to empowerment in the black community. Applying the African American tradition of storytelling, Williams (1992) lists four "acts" in the drama of health-related behavior change, particularly in the area of church-based crack addiction recovery:

- *Recognition*, in which people openly admit to trusted others their true feelings, painful memories, secrets, and experiences of rejection, in order to build their self esteem.

- *Self-definition*, in which people decide who they are and which names are right for them, regardless of their habits, peer attitudes, or environmental problems.
- *Rebirth,* in which people publicly declare their testimonies about personal change.
- *Community*, in which people join with other men and women of every race, class, and sexual orientation to become an extended family.

The open dialogue created by *fotonovela* sharing could promote personal empowerment for behavior change within a supportive environment.

The empowerment of African Americans through unity, concern, and a common vision may require long-term effort but is needed because many feel left out of the system and thus may lack basic tools and resources for AIDS prevention.

A possible key to this empowerment may be that African American mothers put aside pride and defensiveness in order to participate in community parenting. The African village could be a model for this kind of neighborhood-level initiative, and the cultural norms of extended family and sisterhood among African American women could strengthen these parenting networks. The potential for community parenting in Gainesville would depend on whether watching out for others' children would be seen as an invasion of family privacy or an implication that some parents are negligent, as opposed to seeing it as a way of assisting parents with the impossible task of monitoring and offering guidance to children when they are not at home. A possible barrier to community parenting is the attitude among mothers that their children have had superior upbringing that will protect them from harm.

The empowerment to stop the spread of AIDS does not necessarily depend on collaborative efforts, given that individuals could reach out to others within their personal networks on a daily basis, without relying on the structure of a program or group. Within extended family networks, women could serve as godmothers for children who lack a close relationship with their parents.

While women need to be empowered to protect each other's children, youth also may need to be empowered to make independent decisions about sexual involvement. A few possible independent thinking skills may include developing self-identity, assertiveness, refusing to be a follower, learning to say no, assessing others' motives, developing conviction about one's beliefs, and learning to substantiate your views with facts. Teens may be best suited to educate their peers because they are well educated about risks but also may better understand what motivates youth to try risky behaviors.

Compassion

The behavior change strategies used in compassionate Christian outreach could be effective in promoting AIDS preventive behaviors among African Americans who are most at risk of infection. This approach to behavior change involves social support, helping individuals improve their perceived self-efficacy, and promoting open dialogue.

Christian individuals may need to hold certain attitudes before they can effectively engage in compassionate outreach, including a non-judgmental and forgiving attitude, willingness to accept and validate those who have habits or mistakes considered sinful, recognition that these behaviors are part of their real life outside of church, willingness to foster honest, two-way dialogue and mutual trust even when they tell lies

to cover up secrets, commitment to listening and confidentiality, and patience to offer spiritual and emotional support when they refuse or fail to change.

While this kind of outreach may typically be a one-on-one effort, a targeted individual may be more likely to maintain behavior change if he or she is part of a social support network among those involved in outreach. Membership in a support network might follow an invitation to join a neighborhood Bible study group, attend Sunday morning church services, participate in an informative workshop, or to simply join other network members in everyday activities such as shopping or meals.

Reinforcement of religious values

AIDS prevention efforts in the black community may ultimately fail without leadership within the churches, given that the religious institution is at the core of the black community and its heritage. While the influence of family and church may be interdependent, the church may play a more important role in providing leadership and in promoting cohesiveness among many social networks.

Among Christian African Americans, a possible strategy for helping teens protect themselves against the consequences of peer pressure could be to teach them Biblical principles they could use to guide their behavior. Transcending a list of rules or admonitions, this kind of instruction could help teens develop values, a philosophy and worldview to guide their daily decision making and prepare them to rationally and confidently cope with difficult situations.

The religious norm of confessing sin to a minister could reinforce a system of accountability among individuals, such that a minister could help a person involved in risky situations to make behavioral decisions in a more rational or moral way. If spiritual

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counseling could reinforce individuals' religious beliefs, it might persuade them to avoid risky behavior.

Finding theological commonalities among various African American churches, in terms of how those beliefs could support open dialogue about risky behaviors, could unite African American churches to fight AIDS and help strengthen a broader community campaign.

Forging inroads

Many women in churches may be particularly influential and willing to talk to youth about sexual issues and to serve as role models. While African American pastors may tend to be reluctant to discuss AIDS prevention, many women may be more eager to learn and seek resources, tools, and strategies to help initiate prevention efforts. When an official religious leader refuses to address AIDS, some women in a church may be more likely to feel that taking action is their responsibility. This action may take the form of Bible studies, AIDS missions events, discussion groups, video showings, literature distribution, and one-on-one conversations.

Although these kinds of church projects could be launched by influential women and other individuals, a comprehensive AIDS ministry is not likely to be initiated in most churches unless the minister perceives an urgent need that outweighs the possible political consequences.

African American churches may be more likely to collaborate with a change agent when someone within the agency has strong ties to the religious community. In a quest to forge inroads into African American churches, a change agent may need to locate ministers who are most receptive to discussing AIDS. Rather than planning events that

are overtly AIDS-related, African American churches could host health fairs or seminars that promote AIDS awareness within a broader context such as teen sex, health, or violence.

AIDS prevention initiatives that address moral and religious standards, avoid controversial issues like condom use, and use appropriate language may be more likely to succeed in African American churches. The extent that AIDS issues can be discussed within each church may need to be first ascertained. The mission of an AIDS ministry may need to theologically dovetail with the traditional mission of each church. A common mission among most churches is ministry to the physical and spiritual needs of the sick, which could include HIV-positive individuals.

The political climate within a particular church may predict whether it will participate in AIDS initiatives targeting members of that church, members of many churches, or individuals outside the church. This political climate may largely depend on the theological foundation of that church, particularly the extent that the church emphasizes social justice or literal Bible interpretation. Churches that are less fundamentalist could be more willing to host a PLWA as a guest speaker, because fundamentalist religiosity may predict stigmatization of PLWAs because of their perceived association with homosexuality, promiscuity, and other sins.

AIDS education may need to simultaneously occur within many different segments of the community before the spread of the disease could be slowed or halted.

Social support for people living with AIDS

Social support, when framed as compassion, is a basic tenet of most African American church doctrines. Although doctrines may not directly address AIDS

education or outreach, some churches emphasize ministry to all people in need. Although the African American church largely may have failed to provide assistance to PLWAs and to their families, many individuals consider providing social support for PLWAs to be a true Christian's responsibility. Thus, individual Christians could provide empathy and support in their own way even when their church does not.

Events that may help people overcome fear of contagion might include education about AIDS transmission, observation of health care providers who touch and care for PLWAs, the AIDS-related illness of a friend or other loved one, and contact with other PLWAs.

The ministers who were reluctant to assist PLWAs lacked referral information and basic information about counseling, confidentiality, sensitivity, and HIV transmission. As a whole, the black clergy appeared unconcerned and unprepared to provide minimal, emergency help to a person who has tested positive. Information about various local AIDS ministries could provide additional referral resources and help develop acceptance, involvement, networking, and consensus among ministers. A particular kind of information that many ministers may need is practical advice about conducting funerals for people who have died of AIDS, as this may be the only time that some ministers may ever have to deal with the issue publicly.

Structured programs of counseling and skills training should be established to assist PLWAs who feel called to go public with their HIV status. Often a PLWA will not disclose their HIV status until they feel that the long-term benefits of going totally public, through presenting a personal testimony to various groups, outweighs the costs and fears. In recruiting PLWAs to serve as community speakers, organizations must sensitively and

strategically consider the personal consequences that the speaker likely would endure as a result of going public, such as verbal attacks upon those individuals or their families.

While many PLWAs receive tremendous support and a sense of mission by speaking in public, they may not know how to make the first step or fear they lack public speaking skills.
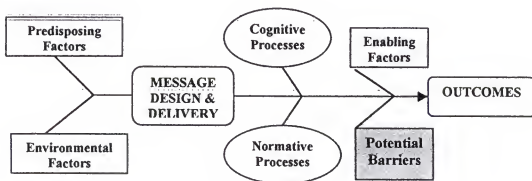
FIGURE 32: Barriers to AIDS Prevention

Potential barriers

Fatalism

For some individuals, a lack of response efficacy may ultimately lead to a sense of fatalism, since they may feel that nothing can effectively protect them from HIV infection. For others, a sense of fatalism may be rooted in fundamentalist religiosity such as a prophetic belief that as long as people sin, diseases will become more and more serious.

The ultimate fatalism, the desire to die, may be pervasive among some African American teens. Prevention advice would be expected to have little influence on a person in a suicidal state of mind. The belief that AIDS might one day be cured may lower the extent of hopelessness among many African Americans, thus increasing self-

efficacy. The need to curb hopelessness may be particularly urgent among African Americans, compared to individuals from other ethnic backgrounds, because of unique social history and conditions.

Fatalism also was a barrier in the *fotonovela* intervention when a person perceived that sharing the booklets would not make an impact on anyone. This belief reflected low response efficacy. When an individual expected that approaching a friend to talk about AIDS would be difficult, this belief was a barrier because it reduced self-efficacy.

Familiarity

The comments and perceptions of teens and women in the focus groups reflected a high level of perceived self-familiarity with AIDS risks. Although awareness is a prerequisite for learning and involvement, familiarity with AIDS or a self-perception of having enough knowledge may inhibit interest in future involvement in behavior change interventions. The attitude also may be a barrier to AIDS dialogue, particularly when individuals perceive that others within their social networks are already knowledgeable. Individuals with high self-perceived familiarity may have lower perceived seriousness of the disease and lower involvement in information seeking.

These findings are consistent with those of a study by Stevenson (1995), which found that African American teens who perceived themselves as highly knowledgeable scored lower on reliable AIDS Knowledge and Prevention Beliefs measures than those who claimed moderate AIDS knowledge. The researchers recommend that the attitudes of some "know it all" teens may reflect a subculture of pseudo-confidence that requires special interventions.

Lack of parent-child communication

A barrier to effective parent-child communication may be parents' lack of knowledge about AIDS or their resistance to learn about the disease. A parent's lack of knowledge about child development or individual differences among children within various age groups could be another barrier to effective communication with youth. Another possible barrier to effective communication is a parent's misunderstandings about a child's sexual curiosity. When youths view their parents as too strict or old-fashioned, this perception may indicate a need for more open dialogue between the parent and child.

Just world belief

The perception that AIDS is a curse from God or that PLWAs deserve their illness is a just world belief, a form of stigma. This belief may be a barrier to AIDS prevention among many religious African Americans because it could lower an individual's perceived susceptibility or perceived threat. If an individual assumes that "bad sinners" are infected because of divine punishment, then conversely a "good Christian" would be expected to escape this punishment through religiosity.

A possible component of a just world belief is the view that some AIDS victims are inherently "innocent" because of the way they were infected. However, a theological rebuttal to that position is that all are sinners.

Many African American churches may be unprepared to minister to PLWAs, given that the number of church members affected by the disease is expected to increase. Even if current members do not become infected, increasing numbers of individuals outside the church may attend church after an HIV diagnosis because they may seek

divine healing, reconciliation with God, or spiritual support from others. A pervasive just world belief likely would inhibit these individuals from seeking refuge in the church.

The religious view that the AIDS epidemic is a fulfillment of Biblical prophecy may contribute to a just world belief. The scriptures often used to support this position describe victims of disease, famine, and other tragedies as foolish, rebellious sinners who spit in the face of God, while those who live righteously and obediently avoid this kind of punishment. Another view that may be common is that the ultimate reason for the AIDS epidemic is the original sin of Adam and Eve.

Labeling a divine punishment belief as a form of ignorance might promote attitude change, but it also might anger individuals who feel threatened. A theological defense for the rejection of a condemnatory attitude might be Christ's "judge not, lest ye be judged" admonition. A message that might help dispel condemnation might be that "no one deserves to get AIDS."

When a judgmental attitude toward PLWAs is widespread, it becomes a major barrier to AIDS-related outreach because it inhibits acts of compassion and blocks perceived susceptibility. People who feel no personal susceptibility to HIV infection may tend to be less effective in doing AIDS outreach.

Denial

Various forms of denial may include individuals' beliefs that they are exempt from the risk of infection, that the disease will never affect them personally, or that ignoring the problem will make it go away. Individuals who hold denial beliefs may be less likely to participate in AIDS awareness initiatives because they do not feel the need to learn about AIDS. A possible strategy for countering this barrier might be to use

AIDS prevention messages that encourage individuals to teach and assist others, rather than try to directly persuade individuals to change their own behavior.

Secrecy

Infidelity, including sex with prostitutes, may be a secret but commonplace activity among many African American men. Judgmental attitudes among ministers could be attributed to their own guilt and hypocrisy. Some ministers may not acknowledge accusations of adultery against a colleague because they want to keep their own adultery a secret. A distrust of the opposite sex among teens may be rooted in a cultural norm of secret infidelity. Despite the perception that most African American teens and adults are not monogamous, teens may fail to respect people who are promiscuous, as well as married adults who commit adultery.

Desensitization by drama

Given that American television is saturated with television dramas and movies, audiences may tend to believe that dramatization of a real problem makes it less likely to actually happen in their own lives. When an AIDS prevention message is presented in a dramatic format, some audience members may dismiss both the script and message as purely fiction or as a scenario that probably would never happen to them. Individuals who are heavy users of entertainment media, particularly those who prefer to watch dramatic television shows more than news, educational programs, talk shows, or documentaries may be more likely to be desensitized to the impact of a dramatic presentation of AIDS prevention information than those who are not heavy users of entertainment media.

Given that a hallmark of "good" acting is the ability to play the role of a character convincingly, individuals who are accustomed to seeing this kind of realistic role playing as part of a fictional film might be less likely to think of themselves as ever confronted with the portrayed situations. It is possible that higher production quality, realistic acting, and use of famous actors might be highly attention getting and involving while placing many audience members in a more passive role of being entertained rather than informed. Conversely, if audience members were convinced that the story were real, they might simply believe that the consequences of risky behavior happened to the specific people in the story because the beliefs that "it's only a movie" or "they're only acting" may be used as fear-coping mechanisms.

The *fotonovela* developed for use in this study likely did not lead to these kinds of responses because it used low fear appeals and used actors who personally knew members of the audience. Thus, it likely would be more difficult for audience members to assume that the story is real when their friends are playing the roles of various characters. While photographs are attention getting, they likely are not as entertaining as video and thus may be less likely to lead to desensitization. Audience members are less likely to be passive when they must read the captions in order to follow the story line.

The context of viewing a dramatic AIDS prevention video or *fotonovela* might influence how an individual reacts and assesses it. Those who view the drama in the presence of peers might be less likely to attend to the educational aspects of the presentation than those who view it alone. If this were true, presentations of dramatic materials to groups would be less likely to lead to recall of specific points than the sharing of dramatic materials within dyads.

Lack of AIDS knowledge

Creating a nonjudgmental environment where no question is considered stupid may be an essential component of any effective AIDS prevention effort. Another related task that may be equally important is dispelling misinformation about AIDS, including inaccurate perceptions of HIV transmission and theories about the origin of AIDS that may be counter-productively inflammatory. The belief that a stranger is the riskiest kind of partner, or perhaps the only kind of partner that could carry the virus, may be a misperception caused by misinformation or lack of knowledge.

Those who ask questions revealing ignorance of basic facts about AIDS or sexuality may be more likely to be involved in risky behaviors, given that they may not have rational reasons to refrain from those behaviors or knowledge about how to use protection. Ignorance about AIDS prevention may be more prevalent among adults than teens, since most teens now receive extensive instruction in schools whereas adults may have little or no exposure to this kind of information. This lack of knowledge among African American adults likely has led to the widespread stigma, fear, and denial in the black community.

The impression that PLWAs look sickly may be a common misconception among African Americans. A possible reason for this perception could be the belief that PLWAs look like gaunt crack cocaine addicts, given that use of this drug is more prevalent in the black community than elsewhere and that many African Americans may assume that crack users are at higher risk of HIV infection.

Another common myth among African Americans, the stereotype that PLWAs are usually white homosexual men, has been blamed on the news media. While the news

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media no longer tend to frame AIDS as a white homosexual disease, African Americans who are news media consumers may generally have a more accurate view of high risk populations than those who are not news consumers. The belief that AIDS is a homosexual disease could serve as a barrier to a person's motivation to learn about AIDS and subsequently become a barrier to dialogue.

If homophobia is a major cause of AIDS stigma in black churches, it may be reflected in the rejection and condemnation of any who practice homosexual behaviors as well as the belief that AIDS is God's punishment of homosexuals. This stigma may drive individuals to practice homosexual or bisexual behaviors in secrecy, which may increase the likelihood that they do not obtain condoms and that they may infect a spouse. Given the cultural lack of acceptance for these individuals in the black community, it is likely that black churches in smaller, more conservative cities would not support an AIDS ministry that openly addresses these issues.

Among African American Christians, homophobia may be partly rooted in the belief that God does not intend for any person to practice homosexual behaviors and thus condemns these behaviors as sin. Even those who are more tolerant may believe that the only homosexuals who deserve acceptance are those who were raped or otherwise forced to practice these behaviors. In addition to being confronted with stigma, a person claiming to be a homosexual might not be accepted unless he or she expressed a willingness to become heterosexual.

Church as protection

Single African American women may be more likely to be lulled into feeling safe from the risk of getting AIDS if they are involved in a church and date men within the

church. Not only may women tend to trust church-going men more than other men, but they may be more likely to have unprotected sex with church-going men because the prospect of eventual marriage may be a greater expectation among religious people. While premarital sex is considered a sin, church-going couples may rationalize it by committing themselves to spending a lifetime together. Even if sexual involvement is delayed for months or years, the risk of infection is not diminished unless both partners submit to an HIV test.

Many African American men "on the prowl" may attend church in order to meet single women, even if these men do not consider themselves to be religious. Some church-going men who become involved in religious activities and volunteer service may be in church for reasons that are not purely spiritual. Given that these motives for church attendance are evidence of extrinsic religiosity, a person whose religiosity is more extrinsic than intrinsic may be more likely to engage in risky behavior.

The belief that God serves as a matchmaker for Christians may lead to blind trust. Women who are more religious may tend to ignore a church-going man's past life, particularly the sexual "sins" he may have committed before declaring himself to be a Christian. While God is assumed to forgive and forget a person's sins, many Christians may feel it is their duty to forgive and forget also. However, this denial of a partner's sexual history may lead to increased risk of HIV infection as a couple becomes intimate.

Church politics

Many African American ministers may not want to address AIDS issues because they fear alienating or offending their congregations. The risk of offending church members may be primarily a political concern. Some may have a marketing motive of

tailoring sermons for maximum audience appeal. Many ministers may avoid addressing controversial AIDS issues if they perceive that AIDS information is already abundant and available to everyone who wants it.

Others may avoid discussing AIDS because they believe that offended individuals will ignore or disregard the message itself. Many religious individuals may attend church primarily because they want others to perceive them as holy, pure, and beyond reproach. The mere mention of an AIDS prevention issue, such as infidelity or premarital sex, may spark defensiveness among many religious adults who question why "good" people need to hear about it.

Religious taboos

AIDS does not rank high on the list of sermon topics among most African American ministers. Some ministers may avoid preaching about AIDS if they do not see the disease literally addressed in Scripture. In some fundamentalist churches, a non-literal interpretation of the Bible is considered an act of heresy.

Moralizing may be a typical characteristic of church-based prevention messages of all types. Sexuality is often considered a taboo topic for Sunday morning sermons. When the topic is addressed, it is often presented as abstinence advice. The incidence of pregnancies among church-going youth, however, shows that this advice does not always promote lasting behavior change.

The efficacy of an abstinence message may not be open for debate in most churches because the discussion of condom use is taboo. Teens who hear this one-sided approach in church but hear about condoms in school and in the mass media may tend to keep their sexual behaviors a secret among religious teens and adults.

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Given that pre-marital sex is taboo, many ministers may not discuss STDs or pregnancy prevention in church because they assume that no church member will ever have sexual intercourse outside of marriage. Preachers also may consider the issue of promiscuity irrelevant when most church pews are filled with senior citizens.

Some may believe they are simply not "called" to deal with AIDS in their own church, and to do so at the request of someone outside the church might be considered an act of disobedience to God's will. The belief that Christians have a variety of divine "callings," according to their individual spiritual gifts, implies that only certain ministers are called by God to initiate AIDS ministry, while the others do not have this duty.

Many African Americans may not likely talk about AIDS or their own risky behaviors in church settings unless a minister or other leader is open and willing to discuss the entire range of problems that individuals might encounter, including such taboos as adultery, drug use, and incest.

Expectation for divine healing

Although sickness is taboo in many religious contexts, some churches believe that a true Christian can receive physical healing from God if they are not living in sin. Conversely, sickness is often viewed as the consequence of sin or demonic bondage. Even ministers who were willing to talk openly about AIDS might tell an infected person to "just have faith" for divine healing, rather than deal with the person's daily emotional and physical needs.

A minister's advice to receive faith healing may be a form of "individual blaming," also an underlying assumption of many health promotion campaigns. The advice to receive divine healing may remove a minister's responsibility to help sick

individuals in the future, and those who are not physically healed through faith are condemned for their lack of faith. In addition, individuals may be expected to receive salvation for their souls before they can receive physical healing.

Many religious African American women, particularly those who perceive themselves as the caretakers for others, may strongly believe that divine healing is a cure for AIDS. These women may also believe that skepticism about divine healing is a barrier to AIDS ministry.

Fear of contagion

The fear of HIV contagion may be widespread in Gainesville, as well as in other communities with a similar population and demographic composition. Although PLWAs have more reason to fear contagion of viral infections from others because they are immunosuppressed, many PLWAs may be forced into isolation by public fear of contagion. Personal acquaintance with a PLWA may reduce fear of contagion. However, a necessary condition for fear reduction may be education about HIV transmission.

Black genocide theory

A belief in black genocide theory often may be rooted in a perceived lack of proof for competing theories. African Americans who support this theory may tend to distrust AIDS prevention advice from government sources, as well as campaign materials that do not address black genocide or that solely promote the "green monkey" theory (the idea that the first humans infected with HIV were Africans infected by monkey bites, eating tainted meat, or bestiality). Another black genocide theory that could hinder AIDS prevention efforts is the so-called "test tube" theory, which asserts that AIDS either was

created as a germ warfare weapon or that it was a variant of a monkey virus that contaminated some polio vaccines administered in the 1950s and 1960s.

The credibility of various competing theories may depend on the source of the information. Belief in black genocide theory may be less common among adults who learn about AIDS from their children, presuming that their children learn about AIDS from school curricula and mass media. Thus, African American children who are taught about AIDS from an "establishment" perspective might not be exposed to black genocide theory. Another anti-establishment theory of the origin of AIDS is the idea that the disease is the consequence of sin.

Stigma

Because of cultural norms of family life, many African Americans may be more likely than whites to associate AIDS with a change in family lifestyle. Because of cultural differences in religiosity, African Americans also may be more likely to dehumanize a PLWA by equating the person with sin or with the disease itself. The use of euphemisms for AIDS may be associated with higher levels of religiosity, but the most probable predictor of the use of euphemism is level of AIDS knowledge. Poor attendance and euphemistic rhetoric at an AIDS patient's funeral may indicate widespread fear and stigma against PLWAs within the community.

The fact that the women associated AIDS with death while the teens did not may be consistent with Whalen's (1995) study, which found that among children in grades 4-8 the frequency of spontaneous mentions of death increased with age. If this pattern applied to African Americans of all ages, then adults would be more likely to mention death than youths.

African American boys may be less likely than girls or women to offer empathy or other support to a friend with HIV, and boys may be more likely to expose or judge such a friend. Even boys who are willing to extend support likely would not be willing to physically touch an infected friend for fear of contagion. In general, boys may be more likely than girls to impose social distance between themselves and PLWAs.

A possible explanation for gender-related differences in the teens' responses to this question may be found in a study by Whalen (1995), in which children in grades 4-8 were asked to consider how they might react if a friend had AIDS. Girls were more likely to express covert reactions, such as sadness and concern over their own vulnerability, while boys were more likely to express overt reactions such as advice, support, or denial.

Secrecy among PLWAs often may be rooted in embarrassment and fear of dying. Many PLWAs may hide their diagnosis from others because they fear rejection of themselves and their families. Stigmatization of PLWAs may be worse in religious contexts, particularly among Christians who shun them as outcasts. Given that lack of knowledge about AIDS can lead to stigmatization of people living with the disease, many church members may need to learn more about HIV transmission before they could begin interacting with PLWAs.

Many PLWAs may not disclose their illness to others for fear of losing their jobs or being prevented from obtaining future employment.

Despite a cultural norm of extended family and an expectation for mutual support among black brothers and sisters, stigmatization and lack of support for PLWAs may be more common among African Americans than among whites. Stigmatization of PLWAs

may sometimes be the result of denial, particularly when the person's illness presents evidence that the disease is spreading through the community.

African Americans who see themselves as openly supportive of PLWAs may be more likely to perceive that other African Americans reject PLWAs. Many African Americans may refuse to become involved in AIDS prevention efforts because they do not want to share the stigma with PLWAs. Another fear response may be condemnation. Others may avoid contact with PLWAs because they do not want to deal with pain. Lack of confidentiality among clergy may inhibit PLWAs from seeking assistance from the church. Church-going African Americans may exacerbate the problem by gossiping.

Another common experience of stigma among many PLWAs is physical isolation within health care settings and lack of needed care from health care workers who fear contagion.

Depression, alienation, fatalism, anger, isolation, and suicidal tendencies afflict many PLWAs, particularly those who do not publicly reveal their HIV status. Keeping their HIV status a secret requires frequent lying and cover-ups, and this lying eventually may make PLWAs feel they are immoral. Many PLWAs fear being stereotyped as immoral, careless, or deserving of the illness, particularly when they contracted HIV through blood transfer in a health care setting, perinatal transmission, or through sexual relations with a spouse or other long-term partner.

The range of sexual dilemmas that PLWAs face may need to be better addressed by community-based AIDS programs, including decisions about whether or how to have casual sex, to disclose their HIV status to a prospective romantic partner, to have sexual relations with an uninfected spouse, or to conceive a child.

Strategies for assisting religious PLWAs in building their spiritual strength through compassionate support, prayer, and Bible study need to be offered through church-based AIDS ministries, particularly within churches that have pledged to assist PLWAs. In more private settings, ministers educated about HIV could provide confidential counseling and spiritual guidance.
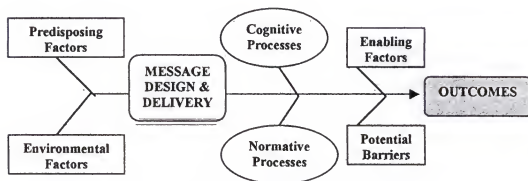
FIGURE 33: Outcomes of an AIDS Prevention Campaign

Outcomes

Identification

Given that the *fotonovela* contained photographs of the teens that helped create the drama, it generated popular interest within youth social networks in much the same way that a school yearbook might. Teens were flattered to see themselves in print, while their friends curiously looked for photos of people they know. Seeing familiar faces may have helped personalize the prevention message as well, and it may have increased perceived susceptibility among teens that realized that people like themselves may be at risk.

Although teens tended to perceive that their friends will learn more than they themselves did, they also perceived that their friends would be less likely to put the prevention advice into practice.

The message that teens die of AIDS was included in the *fotonovela* without reliance on high fear appeals. Perceived susceptibility prior to reading the *fotonovela* may have influenced the extent that the portrayal of everyday versus tragic situations affected individuals' responses. A *fotonovela* that depicts everyday situations among African American teens may be seen as more credible and realistic but also more mild when compared with traditional AIDS prevention literature. This approach also may promote higher levels of identification as the story characters are portrayed as typical youth dealing with familiar situations, within a culturally specific context of prescriptive and popular norms, and using everyday language.

The modeling of preventive behaviors in the *fotonovela*, such as sexual negotiation with a partner, is not only information that teens want, but it could help them prevent the transmission of HIV. Given that youth wanted to identify with characters portrayed as "cool," the story characters portrayed as having the most social clout may need to be the ones that make the smartest decisions. Since many young teens were curious about the opposite sex, scripts that provided insight into the way that boys and girls view relationships appeared to be particularly appealing among readers in this age group.

The use of familiar situations, language, and faces was expected to more effectively lead to open dialogue about AIDS prevention, given that the portrayal of tragic circumstances could be unfamiliar and threatening and could prompt a denial

response. While the portrayal of everyday situations was readily accepted and understood, depicting the tragic consequences of AIDS could have made a more lasting impact on teen behavior.

Attitude change

The widespread and rapid dissemination of an AIDS prevention *fotonovela* among teens helped build a sense of enthusiasm, momentum, ownership of the issue, and perceived self-efficacy in educating others. This excitement also helped adults gain a sense of self-efficacy in initiating conversations about sexuality with their children or with youth who are part of their extended families or who live in their neighborhoods. When youth appeared to be hungry to learn more about AIDS and sexuality, as shown by their interest in reading a *fotonovela*, the task of educating them did not seem so daunting to many adults.

Some participants who felt more concerned about the susceptibility of others than their own susceptibility to AIDS expressed greater willingness to share the booklets with others. Similarly, after sharing the *fotonovela*, many teens perceived their friends to be more afraid of getting AIDS than they themselves were. This perception may be associated with their desire to change their friends' way of thinking or to feel that their education efforts are successful.

Awareness

The *fotonovela* intervention appeared to spark AIDS awareness among many individuals who were not directly targeted but who belonged to the social networks of target audience members. This "spreading of the word" may have been or could be a key factor in changing popular norms.

AIDS dialogue

In light of diffusion of innovations theory, many ministers and other religious leaders in the black community community were reluctant to engage in dialogue about AIDS or to adopt any kind of AIDS ministry. A change agent might develop specific interventions and materials to persuade this audience that the need for an AIDS ministry outweighs the political risks.

Youth who gave a positive evaluation of the *fotonovela* appeared to be more willing to share it with peers. They also were less likely to anticipate reactions of shyness or embarrassment from their peers. Boys were more likely than girls to react to a *fotonovela* intervention with defensive reactions like bragging and joking. Comments that were unrelated to AIDS prevention, such as a recipient's curiosity about the identity of actors in the photos, may have led to open dialogue about sex or AIDS just as effectively as questions initiated by the presenter.

The focus group discussions about AIDS dialogue actually modeled the kind of conversations that individuals might initiate with others. These moderated discussions, along with script writing, interpersonal skills training, and other activities, promoted involvement in dialogue and learning.

Teens who were trained to initiate discussion about a *fotonovela* with their friends appeared could cope with potentially embarrassing questions about their virginity, how their photos looked, and their involvement in the *fotonovela* project. When women shared a *fotonovela* with teens, the boys were more likely than girls to ask questions or volunteer comments, at least initially. A possible explanation is that the girls were more

worried about giving adults the impression that they are sexually knowledgeable or experienced.

Fear of a brush off, disagreement, or other rejection could have been a barrier to interpersonal dissemination of a *fotonovela*. A barrier to effective dialogue about a *fotonovela* between teens was the presence of adults or peers. Too much talk by one person in a dyad was a barrier to focused conversation about a *fotonovela*.

Willingness to initiate AIDS dialogue

The youth that helped create the *fotonovela* were less shy and more eager to share it with peers. The group discussions about the *fotonovela* appeared to increase perceived self-efficacy in sharing the booklet, since each person did not feel alone or isolated in the endeavor. Having each youth participant identify specific friends with which to share the booklet also appeared to enhance a sense of self-confidence.

The follow-up discussion group, as well as the ongoing comments of peers appeared to provide the accountability needed to motivate individuals to go out and share the *fotonovelas* with others within a specified time period. Some individuals may have wanted to avoid the potential embarrassment of being the only person to not have shared at least one *fotonovela* with someone else. Teens who did not consider themselves to be popular saw their participation in the *fotonovela* intervention as an opportunity to make new friends or become more accepted within a social network.

Adults with weak social ties with youth were at least as enthusiastic and effective as parents, siblings, or close friends in motivating teens to read and discuss the *fotonovelas*.

Limitations

The *fotonovela* demonstration is a promising, innovative approach to AIDS education among African American youth, and the triangulation of qualitative methods is a rigorous approach to inquiry and a practical strategy for future development of prevention initiatives. However, several limitations in the study should be considered.

The limitations of qualitative research necessarily include the use of self-reported data, the lack of quantification of attitudes and beliefs, and the lack of generalizability.

Qualitative data are non-quantifiable and thus elude standard statistical analyses (Morgan, 1988; Stewart & Shamdasani, 1990). The results cannot be projected to a larger population. In order to establish generalizability, wider-scale, quantitatively assessed interventions in Gainesville and in other cities of similar size and ethnic composition would be needed. A baseline survey of knowledge and attitudes, as well as an experimental, pretest-posttest assessment of intervention effectiveness would be needed for this kind of evaluation.

The interviews yielded rich insights into the perceptions, experiences, and attitudes of the target population and are intended to indicate the feelings or beliefs that surround particular behaviors. The purpose of the interviews and focus groups was not to generalize across Florida and the United States, but to generate theory constructs, to develop survey instruments in the future, and to inform HIV prevention specialists and other health communicators about the needs of African Americans and about how a prevention tool might be used to serve African American populations in the future.

Given that the causal relationships among variables proposed in the theoretical model were based on the literature review, actual causation should be confirmed through experimental research.

The investigator's reliance upon health behavior theory may have affected the conduct of the study, as well as subsequent interpretations of the narrative results. While the use of a theoretical framework for organizing data interpretations helped modify existing theory, generate new theory, and produce numerous directions for future research, it also may have introduced bias by excluding some alternate interpretations.

Another limitation was the lack of ethnic homophily between the investigator and the study population. Traditional advice about conducting qualitative research suggests that women should study women's problems, and that African American researchers should study scenes populated by African Americans (Lindlof, 1995). Thus, the investigator's role as a Caucasian researcher could have been considered a barrier to her smooth initiation into the black community, to meaningful field relations, to having advance detailed knowledge of the culture, and to the collection of the highest quality data. However, an ethnically dissimilar researcher could gain greater insights from the interaction of differences and from the outside perspective of styles, codes, social skills, and artifacts. All else being equal, the quality of data collection and interpretation likely depends more upon the consistency, thoroughness, and rigor of the methodology than the amount of homophily between the researcher and subjects.

To reduce the possible effects of researcher ethnicity and researcher intrusion during sensitive discussions, four African Americans were trained to serve as moderators for the focus group sessions. The moderator of each group was similar to the participants

in ethnicity, gender, age, and socio-economic background. In addition, the *fotonovela* evaluators were African American and adolescents, which were the primary characteristics of the target audience.

Only church-going women and youth, all of whom came from lower-income backgrounds, were studied as key opinion leaders in the *fotonovela* demonstration.

The study relies on self-reports of experiences, attitudes, and beliefs. In addition, many data-texts were obtained in focus group settings, in which some individuals may have felt shyness or embarrassment in the presence of peers.

Implications for Future *Fotonovela* Interventions

Using fear appeals in a *fotonovela*, particularly among African American boys, could backfire if a fear response threatened their self-perceived image of toughness and led them to challenge each other to prove their fearlessness by engaging in the dangerous activity. The use of humor in a *fotonovela* could enhance recall and involvement, but it also could be hazardous. Humor must rate high in culture- and age-appropriateness, and it must not be offensive to females.

Merely handing out copies of the booklet, without this kind of interpersonal involvement, might interest youth enough to get them to read the booklet and talk about it but not enough to motivate them to share it with others. Future *fotonovela* interventions could target specific neighborhoods for *fotonovela* workshops and discussion groups. A leader within each neighborhood could be appointed to monitor the progress of a neighborhood *fotonovela* project and to distribute copies of a *fotonovela* and accompanying materials to those who request them.

The future distribution of *fotonovelas* in the African American community could be accomplished through both traditional and non-traditional channels, including direct mail, tabling events, school distribution in connection with a guest speaker or curricula, and distribution through health care offices, work sites, and businesses. Since the *fotonovela* used in this study was designed to serve as a tool for interpersonal dialogue, future distribution strategies could target those who could serve as opinion leaders among teens such as youth ministers, parents, church lay leaders, counselors, teachers, as well as the youth themselves.

The intended use of a *fotonovela* does not need to be limited to peer or parent-child interactions. Ideally, a *fotonovela* dissemination strategy should include group discussion, communication skills training, and AIDS education for the individuals who intend to share the booklets with others.

An AIDS prevention *fotonovela* for African American youth should be tailored for narrowly defined age groups because sexuality discussion should be developmentally appropriate. For example, a *fotonovela* targeting middle-school aged youth likely would not be appropriate for high school students, or vice versa. The average onset of sexual involvement among African American youth, within a particular community, could help delineate the age boundaries as well as the appropriateness of prevention messages.

An accompanying sheet providing tips and sample questions for sharing the booklet could be developed for these opinion leaders. Within various neighborhoods in the black community, *fotonovelas* also could be used as a tool to organize small groups of youth to discuss and learn about AIDS issues. In the future, a *fotonovela* could be developed as one component of a multimedia AIDS prevention campaign targeting

African American youth. Other components of the campaign could include a video version of the drama, as well as a focus group leaders' guide and a school curriculum that includes discussion questions and classroom activities. This recommendation is based on suggestions from focus group participants and observations of their reactions to the "On the Pillow" video and subsequent discussion sessions.

The selection of factual information and prevention advice to include in a *fotonovela* must be carefully considered, since the format does not permit unlimited space for this kind of material. The information should be limited to facts most pertinent for the target audience, written in language that is easily recalled. The use of statistics could increase perceived credibility of a *fotonovela*. Slang, statistics, and risk factors probably would need to be updated at least once a year.

A *fotonovela* targeting African American youth likely would have much broader appeal if it included raps. Raps also may greatly enhance recall of an AIDS message because the lines rhyme, and the readers may frequently recite the lines aloud. A rap writing workshop, led by a respected and skilled rapper from the community, could lead to a high level of involvement among targeted youth in producing and disseminating a *fotonovela*.

Similarly, Quirk (1993) used raps in an AIDS prevention video targeting African American adolescent girls and young adult women. They found that when the rap video was used as part of a peer education intervention, it led to significant improvements in AIDS knowledge, to the belief that asking a sexual partner about past sexual experience would now be less difficult, and to a significant decrease in the frequency of sex.

A *fotonovela*'s advice may not become salient until teens find themselves in the situations portrayed in the story. If boys are more likely than girls to have sex spontaneously, then an AIDS prevention *fotonovela* should portray boys dealing with situations where this might occur.

An advantage of a dramatic presentation of AIDS prevention advice is that it can whet a reader's curiosity to see what happens next in the lives of the story characters. The development of future *fotonovelas* could involve youth in writing sequels to previous stories. This strategy could promote higher levels of awareness, involvement, and reinforcement of learning.

The evolution and re-invention of the *fotonovela* through sequel writing might increase the likelihood that the story lines would address familiar predicaments, particularly if a different youth group was involved in creating each *fotonovela*. In addition, the producer of a *telenovela*, *radionovela*, or educational video could splice the sequels together to form an ongoing drama.

A multimedia strategy is consistent with the findings of a survey by O'Donnell (1995), who found that minority STD clinic patients assigned to video viewing demonstrated greater knowledge about condoms and STDs, more positive attitudes about condom use, increased HIV/STD risk perceptions, greater self-efficacy, and higher rates of condom acquisition. The patients who were additionally assigned to interactive sessions following the video viewing demonstrated still further increases in risk perceptions, self-efficacy, and condom acquisition, but the interactive sessions did not lead to an increase in knowledge or positive condom attitudes.

Future Research

Future research could explore whether African American adult men or individuals from higher socio-economic backgrounds could serve as well as adolescents and women from lower socio-economic backgrounds as agents of influence within key social networks in the black community.

While African American teens from a low-income environment may aspire to become professionals, future research is needed to explore how faith in these dreams and ties to their ethnic heritage can influence their desire to postpone sexual involvement. Related research could explore the rationality of sexual decision making among African American adolescents.

A study of church power and empowerment in African American churches is needed to examine the leadership factors that influence individual AIDS knowledge, attitudes, and behaviors, including dialogue in various settings. Studies are needed to ascertain the extent that African American churches from various denominations in a particular community fail to acknowledge or respond to the local AIDS situation, as well as to determine the extent and types of AIDS dialogue that is initiated within those churches. Lack of interest in AIDS ministry, as well as expressions of apathy or fear, may reflect feelings of denial among African American ministers. Related research could explore ministers' use of euphemisms in religious discussion about AIDS.

Further research also could explore whether an individual's level of perceived spirituality could enable AIDS preventive behavior. A study also could explore the extent that African Americans tend to rely on this kind of spirituality for decision making about their own behaviors.

Given that Christians who deliberately commit sin or who withdraw from church are labeled as "backslidden," future research could explore the intellectual and emotional stages of change that a "backslidden" Christian passes through before a particular sin becomes habitual. Related studies could explore why many churches ignore backsliders while others reach out to them, as well as a comparison of health beliefs among those who perceive themselves as backsliders versus those who are highly religious. Further research also could explore whether an individual's level of perceived spirituality could serve to enable preventive behavior, as well as explore the extent that African Americans tend to rely on this kind of spirituality for decision making about their own behaviors.

A future study could assess the extent that the black church is an effective site for AIDS dialogue, through the quantitative assessment of eight dependent variables: AIDS knowledge and beliefs, religiosity, peer influence, ties within social networks, sources of AIDS information, media use, attitudes about sexuality, and demographics. Using this data, specific recommendations and a plan for a church-based AIDS campaign could be developed. A related study explaining how religiosity-related schemas are correlated with specific AIDS-related attitudes and behaviors among African Americans could produce a path model of variable linkages as well as additional strategies for developing AIDS prevention interventions for religious contexts.

Additional research, including pre-testing and trial demonstrations, should evaluate the efficacy of *fotonovelas* targeting a variety of population segments, including adolescent girls only, boys, women, young men, clergy, or residents of subsidized housing neighborhoods. Related research is needed to determine which settings are most appropriate for dissemination of *fotonovelas*. The use of *fotonovelas* in concert with

telenovelas and/or *radionovelas* in a single HIV prevention campaign also should be studied, and future research also should compare the effectiveness and uses of these three channels in various contexts.

Pre-testing of a *fotonovela* should include a microanalysis of story components. Target audience members should evaluate every scene, line of script, and graphic element of a *fotonovela* to assess the level of realism and how well these individuals identify with the story. These evaluators should be asked to flag unfamiliar words, scenes that do not fit their experiences, and inappropriate facial expressions in photos.

Pre- and post-intervention evaluation is needed to ascertain the persuasiveness of a *fotonovela*. To assess the behavioral impact of a *fotonovela* intervention, trusted adults not visibly associated with the intervention could ask youth informal questions about their views, intentions, and behaviors.

A study is needed to quantify whether and to what extent that constructive AIDS dialogue is more effectively promoted by having adults present *fotonovelas* to adolescents than by having teens present the booklets to their peers. Further research also is needed to compare the outcomes of using varying levels of fear appeals in *fotonovelas*. Additional evaluation is needed to test font preferences among African American teens, or the possibility of having teens design original fonts or logos for *fotonovelas*.

A detailed, step-by-step guide could be developed to facilitate development, use, and distribution of *fotonovelas* and offer tools and techniques for intervention leaders. Logistical difficulties, lack of resources, lower literacy, and other barriers encountered during trial interventions could serve as a basis for additional training of intervention leaders. The guide also could include a "starter set" of *fotonovela* materials, a template

for ongoing monitoring of the use, acceptability, and future improvement of *fotonovela* materials, and a set of guidelines for integrating *fotonovelas* with outreach programs.

Future research could assess the effectiveness of a full-scale *fotonovela* intervention in African-American churches. On-going, evaluative in-depth interviews could be conducted with both *fotonovela* intervention leaders and participants. Experimental or quasi-experimental pre- and post-intervention surveys of volunteer leaders and the participants who receive the *fotonovelas*, including use of a control group, could be used to determine whether the *fotonovela* elicited desired changes in knowledge, attitudes or behaviors. The post-test survey also could collect feedback about the intervention so that future interventions could be adjusted and improved. Although such an evaluation may yield incomplete information about disease prevention, it could serve as a source of direct feedback on the performance of those delivering the intervention.

Additional recommendations for a church-based, AIDS prevention *fotonovela* campaign could be developed by linking survey findings with the qualitative implications of the present study. The collection of baseline survey data could provide information about individuals' risk factors, knowledge, attitudes, community attachments, and demographics. Survey work also may call for the development of an original, culturally relevant scale to assess health beliefs or religiosity factors. Survey sociometry, in which respondents are asked to identify their social linkages, could provide additional information about communication patterns within African American churches.

Future research could ascertain the most appropriate and culturally specific strategy for promoting AIDS dialogue in all relevant segments of the community, including churches, families, schools, and neighborhoods. In cities that have a large

Hispanic population, a multi-ethnic approach to AIDS prevention might be more effective than a separate initiative targeting African Americans if the unity among various minority groups provided more resources and momentum to accomplish common goals. Community events also should be examined, including AIDS education events in churches and other community organizations, news media coverage of AIDS-related issues and events, health screening events, and AIDS-related professional education seminars.

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The following table summarizes the key facts about data collection based on the long interview protocols.

Appendix	Informant Type	Number of Interviews	Pages of Transcripts
	Key informants		
A-1	AIDS organization leaders	5	26
A-1	Church members	1	2
	Formal member check	1	3
A-2	Clergy	3	21
A-3	*Fotonovela* evaluators	2	5
A-4	People living with AIDS	1	7
Totals		**13**	**69**

- What, in your opinion, should the major goals for the task force be?

- Where do you think the task force will go from here? What is your vision?

- What led you to become involved with the task force?

- How big of a problem is AIDS in Gainesville? In the African American community?

- How should the black community confront the AIDS problem?

- I wonder if you know of any specific, local situations that put African Americans at risk?

- How should AIDS education be approached differently for African Americans than for others?

- Is prostitution and intravenous drug use a problem in Gainesville? If so, what makes you think that?

- Where do local youth learn about AIDS?

- Do you think the local churches are really reaching out to youth?

- Why are youth involved / not involved in the churches?

- Has AIDS touched your church or affected anyone personally? If so, how?

- Do you think there is any resistance or discomfort about discussing AIDS in your church?

- What kinds of AIDS-related outreach would be appropriate in your church?

- As far as you know, are any black churches here dealing with AIDS issues?

- How much responsibility do churches have to deal with AIDS, even if people who go to church are not personally affected by it?

- Is drug or alcohol abuse discussed in church, or should it be?

- Does your church discuss the issue of sex outside of marriage?

- What do you think about the abstinence issue – should we give youth safe sex information, too?

- Would your church ever talk about condoms? Why or why not?

- Do you ever give the youth any advice about sex?

- Is there open communication going on in your church between kids and adults?

- When you were growing up, did you have an environment like that in your home or church?

- Did you ever go to anyone else besides your parents, that you really trusted?

- If someone with AIDS or a homosexual visited your church, what would happen?

- How would people in your church react if someone in the congregation had AIDS?

- What are some differences between black churches and white churches?

Community questions

- What is your perception of AIDS in our community?

- Do you consider AIDS to be a serious problem in the local African American community? Could you explain more about that / give me an example?

- What kinds of goals should the black community, as a whole, establish to confront this problem?

Church questions

- Overall, how are the black churches in our community dealing with AIDS?

- What have you heard that other churches have done? How effective are those programs?

- Do you think local churches can help provide solutions to the AIDS problem in the African American community? How so?

- How would you define the responsibility of the church:
    - In providing ministry to people with AIDS/HIV in the African American community?
    - In providing information and education about AIDS?

- Which of the following should the church discourage? How so?
    - drug/alcohol use and abuse
    - sex outside marriage (promote abstinence)
    - ignorance about STD protection (promote condoms)
    - fear or rejection of people with AIDS
    - hate or lack of tolerance toward homosexuals

- What would be the wisest way to introduce AIDS awareness into the churches here?

Questions about your church

- What are some obstacles or challenges in dealing with AIDS-related issues in your church?

- Do you think the attitudes in your church (about AIDS) are different from other churches? How so?

- Are there aspects of your denomination's theology that help form these attitudes?

- How would you define the responsibility of your own church in AIDS ministry and education?

- How would you proceed in your own church? What are some specific ministry needs?

- Do you personally know anyone with HIV or AIDS? Has anyone gone public with his or her AIDS diagnosis in your church? (If so, what was/is the response?)

- Has anyone with AIDS sought your counsel or come to you for help? If so, tell me more about that experience.

- How do you think your congregation would respond to a person with AIDS?
    - If a PLWA spoke from the pulpit?
    - If a PLWA attended a church service for ministry, healing, or prayer?
    - If a PLWA requested church support: financial, food, visitation, etc.?

- Which of the following topics would be OK to discuss: in a Sunday school class, Bible study or prayer meeting, special workshop, worship service, sermons, or through community outreach? (And why?)
    - abstinence
    - drug/alcohol abuse
    - AIDS / HIV issues
    - teen pregnancy
    - safer sex / condoms
    - healthy lifestyle issues
    - homosexuality
    - promiscuity
    - compassion for sinners

- In evaluating and respecting the comfort level of your own congregation, how would you feel about your church participating in these kinds of AIDS/HIV outreach activities for people with AIDS (PWAs):
    - __ pastoral counseling for those affected by AIDS
    - __ healing service or day of fasting
    - __ food bank/meals program
    - __ visit a PWA in his/her home, the hospital, or in prison
    - __ clean a PWA's home / provide housekeeping assistance
    - __ participate in an AIDS benefit concert (local church choirs and speakers)
    - __ hugging ministry
    - __ open church facilities for informal support group meetings
    - __ participate in a fund-raising concert/other event for AIDS awareness/outreach
    - __ greeting card ministry
    - __ Buddy / companion program for people with AIDS
    - __ host a guest speaker who has AIDS
    - __ make quilt panels in memory of local African American individuals who died of AIDS
    - __ love offerings for PWA and families affected by AIDS

- What about these kinds of AIDS awareness activities?

  __ give clear directions / referrals to those who need help
  __ sponsor a worship service focused on the AIDS problem
  __ make bulletin boards about AIDS awareness
  __ share AIDS concerns at prayer groups or prayer breakfast
  __ candlelight vigil for AIDS awareness and people with AIDS
  __ attend AIDS educator training sessions for information and support resources
  __ consciousness-raising, motivational sermons about AIDS-related issues
  __ sponsor awareness and educational workshops for parents, grandparents, and
      teens
  __ participate in an interfaith church health fair to promote AIDS awareness
  __ AIDS awareness workshops in prisons or juvenile detention centers
  __ develop a peer educator program in your church ("each one, teach one")
  __ lead educational seminars in other churches
  __ participate in a county-wide AIDS awareness campaign
  __ street ministry: pass out brochures about AIDS and/or condoms to teens
  __ establish a substance abuse ministry

- What are some goals/possible goals for your own congregation in dealing with AIDS?

Questions about proposed interventions

- Would you consider having a team of peer counselors from another black church
  present an informational class or workshop about AIDS awareness in your church?

- Do you think anyone in your congregation might be interested in being trained to do
  this?

- If several churches sponsored a seminar/workshop about AIDS awareness / ministry,
  would you consider:
    - Attending it or appointing a representative from your church?
    - Announcing it in your church newsletter, bulletin board, or pulpit?
    - Helping to sponsor it?

- We are organizing a special breakfast for pastors in the African American community
  that will introduce some of these AIDS-related concerns. What kinds of issues do
  you think we should address in this forum?

- Would you be interested in obtaining and using free church-related AIDS materials in
  your church, such as scripture booklets, church bulletin inserts, youth program
  curricula, videotapes, and other resource materials?

APPENDIX A-3
FOTONOVELA **EVALUATOR QUESTIONS**

GENERAL REACTIONS

- I'd like to know what you thought was the best thing about this, what you liked the most about it?

- I'm interested to hear what you thought was the worst thing, or what you liked the least about it?

- I wonder how the girls / boys in the focus groups will react.

THE CHARACTERS

- How are the people in the booklet like people you know? [PROMPTS: What about Kevin? Josh? Samantha? Tatiana?]

- How are they different from people you know?

- I wonder if any of the characters are similar to you? [PROMPT: If so, how?]

- How are they different from you?

REALISM

- Some people might think this story is realistic, while others might think it's not. I'd like to hear your reactions.

- I'm curious if any of the situations in the story have happened to people you know.

THE MESSAGE

- I'd like you to tell me the most important things you learned from the story.

- What is the moral or overall lesson of the story?

- I wonder if the lesson of the story could be different? What kind of lesson would you use?

- OK, before we move on, I want to see if there's anything else you'd like to say about your reactions to the story.

LANGUAGE

- I'm curious if you saw any words or sentences or other parts of the story that might be confusing or hard for middle-school aged kids to understand. Is it easy to read? Well organized?

- I wonder if you can find any words that seem out of place? [PROMPT: Some kids might think that some words are unfamiliar, cheesy, or offensive.]

- What are some slang words or rhyming words that we could add to make it more interesting or real?

- What do you think about using rap in this booklet?

- Should the tone be more serious or humorous? More hip? Do you think it is interesting? Would most African American teens be motivated to read this? Why or why not?

REACTIONS TO THE STORY

- I want to know the kinds of moods the story put you in when you read it.

- I'm interested to know if you think any parts of the story are funny? Scary? Which parts are you talking about?

- How interesting was the story to you? Why?

- I wonder why your friends would be interested in reading this?

- Some kids might say this story is too serious or boring or goody-goody. What do you think?

- Can you think of anything that would make the story more interesting or especially appropriate for African American teens?

- Can you think of how somebody's past history or background might affect his or her attitude about this booklet?

LESSON OF THE STORY

- First, I'd like you to tell me the main things the kids might learn from this story?

- I'm interested to know if you learned anything new about AIDS from the information on the back.

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- I wonder if you can think of any other information about AIDS that should be included.

- If you could change any part of this story, what would you change? [PROMPTS: How would you change it? What are some other stories, characters, situations we could write about?]

- I'm interested to hear any other ideas you'd like to add about the story or the booklet.

- Some people might think it's hard to share this booklet or talk about AIDS with their friends. I'm interested to know how you'd feel about doing this? Do you think that would be hard to do?

- Some kids might feel embarrassed or mad about being asked to talk about this booklet. How would you feel if somebody handed you this booklet?

- What are some good things you could you say to start a conversation with somebody? What kinds of things would not work very well?

- I'd like to think of some places where it would be easier to show friends this booklet and talk about it.

- Have you ever talked with anybody about AIDS to try to get them to be more careful?

- How do you feel about sharing this booklet with other kids, to talk to them about AIDS?

- Can you think of any reasons it might be hard to do this? [PROMPT: How would you deal with these problems?]

APPENDIX A-4
QUESTIONS FOR PERSONS LIVING WITH AIDS

- How did you find out that you were HIV positive? How did you contract the disease? How long have you known? How old are you now?

- How has AIDS changed your life?

- How many people know that you have it? What are some different reactions from people, when they found out? How do they treat you?

- What are the best experiences you have had? The worst or most negative?

- Have you dealt with any stigma or rejection? How do people act? Why do people act that way?

- Do you think there are barriers to talking about AIDS in the African American community? Are there barriers in the churches? What are they? Why?

- Have you been involved in a AIDS support group or other program like that?

- Why would you want to "go public"? Or why not?

- How big of a problem is AIDS in Gainesville? In the African American community?

- What are some things the black community should do to deal with the AIDS problem?

- Should AIDS education be approached differently for African Americans than for whites?

- How or where did you first learn about AIDS?

- Do you think there would be any resistance or discomfort about discussing AIDS in your church?

- Why are people afraid to talk about AIDS?

- What kinds of AIDS-related outreach would be appropriate in church?

- In your experience, how are black churches here dealing with AIDS issues?

- How do you think the people in your church would react, at first, if they all knew you had AIDS?

- What did you think about the story booklet?

APPENDIX B
FOCUS GROUPS PROTOCOLS

The following table summarizes key facts about the data collection performed using the focus group protocols:

Appendix	Group Type	Primary Objective	Number of Participants	Pages of Transcripts
B-1	Boys	Baseline	9	9
B-2	Girls	Baseline	11	13
B-3	Youth (Boys & Girls)	*Fotonovela* evaluation	12	20
B-4	Youth (Boys & Girls)	*Fotonovela* follow-up	15	10
B-5	Women	Baseline	6	37
B-6	Women	*Fotonovela* follow-up	12	33
B-7	Pilot study (Boys & Girls)	Baseline	20	16
Totals			**85**	**138**

Moderator_____

Date_____

Place _____

Start time _____   Ending time_____

Group type (check one):   ____ Girls   _X_ Boys

Number participants in focus group_____

Youth Assent Script

My name is _____, and I am a student at _____.
I am working as a research assistant on a project for Kristie Swain. Kristie is a doctoral
student at the University of Florida.

If it's OK with you, I will ask you and your friends a few questions about AIDS issues.
I cannot give you money or prizes for talking with me. Your views about AIDS are very
important because your ideas and opinions could help us find ways to save other kids
from getting AIDS. You may benefit from this project by learning about things you can
do to help slow the spread of AIDS in our community.

I will be tape recording this discussion, but only those who are conducting this project
will have access to these tapes. Your name will not be included in the report about this
project. I won't tell your teacher or family or friends anything you say today in this
group.

You do not have to answer any question you do not want to answer. You can withdraw
from the group any time. If you have any questions, please ask me.

Introduction

I will be leading the group discussion today, and it will last between an hour to an hour
and a half. Afterwards, we will have a pizza party.

Today we will focus on what you think about AIDS and some issues related to AIDS like
drugs and sex. Your views are important to me because I'm interested to learn more
about how kids your age think about AIDS. Your opinions may be used to make a
booklet that could help save other kids from getting AIDS.
I am not here to provide information to you or to present a point of view. I simply want
to find out what you think. From my point of view, there are no right or wrong answers –
just opinions, feelings, and reactions. I want to hear those from you.

GROUND RULES

First of all, I'd like to set up a few basic ground rules for our discussion:

1. I can guarantee my confidentiality and that of the tapes, but of course I can't guarantee yours. So I'm asking you to agree to not repeat others' comments from today to anyone else. This will make it easier for all of us to talk openly.

2. I'm going to ask that only one person talk at a time, so I can hear each of your ideas and so everybody gets a chance to have a say in our discussion. Everyone will have the chance to participate. When someone is talking, I would ask that everyone else be very quiet.

3. Please raise your hand whenever you want to say something. When several people want to respond at the same time, I will call on you randomly.

4. On some of the topics we'll talk about, it's natural for people to have different points of view and maybe even disagreements. I am interested in ALL of your ideas, whether they are the same or different from those of others. Feel free to say you disagree, if you do. But I want you to give each other the time to talk and listen to each other with respect.

MODERATORS:
Reminders about Reflective Listening

After asking major open questions, or before moving to a new topic, remember to summarize the topic discussion by restating one or two of the most important views that were said about that topic. Whenever you see the cue [SUMMARIZE], use your judgment about whether to make a summary statement before moving on – if the discussion needs closure because various views have been expressed or because you need to re-focus the discussion, etc.)

To SUMMARIZE, use a reflective listening (mirroring) statement – start it by saying something like:
"It sounds like you are saying that…"   "What you seem to be saying is that…"
"What I hear you saying is that…"   "You are worried that…"
"Some of you seem to be saying…, while some of you seem to feel that…"

After you SUMMARIZE, give the kids a chance to elaborate on or clarify your summary before you move on to a new set of questions.

⇒ These are **KEY** questions (the ones you might spend more time talking about).

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SHOW THE VIDEO        [8 minutes]
[Kristie will show the "On the Pillow" video, which lasts about 8 minutes.]
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INTRODUCTIONS   [5 minutes]

I'd like you to introduce yourself by your first name, your age, and what you would like
to do after you graduate from high school.

LEAD-IN: Today, we will be discussing five different AIDS-related topics.
I'd like to get started with your overall reactions to the video we just watched.

REACTIONS TO VIDEO   [15-20 minutes]

⇒ I'm interested in what you liked or disliked about the video.

- What are your feelings about it?

- I wonder if you think the girls in the other group would react differently than you
  did. [PROMPT: How?]

- Some people might think this video is realistic, while others might think it's not.
  I'd like to hear your reactions.

- How are the people in the video like people you know? How are they different?

- Are any of the characters similar to you? [PROMPT: If so, how?] How are they
  different from you?

⇒ What is the moral or overall lesson of the story?

[SUMMARIZE].

OK, before we move on, I want to see if there's anything else you'd like to say about
your reactions to the video.

[TRANSITION]: As you saw in the video, AIDS has become an important issue for
African American teens today. I am interested in finding out how teens like yourselves
think about AIDS, in general.

AIDS – IN GENERAL   [40-45 minutes]

⇒ What do you think of when you hear the word "AIDS"? I'd like to hear your feelings or reactions.

1. AIDS KNOWLEDGE

- I'm curious about what you've heard about where AIDS comes from.

- How did AIDS get started? [*OPTIONAL*: Some people say that somebody created AIDS to kill people in Africa. Have you ever heard that? I'm curious to know what you think.]

- I'd like to hear some different ways that a person can get AIDS.

- How can you tell if somebody has AIDS?

- Among your family, friends, and kids you know at school or church, can you think of anybody who is probably <u>not</u> at risk of getting AIDS? [FOLLOW-UP: Why are they safe from getting AIDS?]

- I'd like you to think back over the last few years, about where you remember getting the most information about AIDS. [PROMPT: From school, your friends, TV, or from some other place?]

- I've heard that teachers at school sometimes give advice about AIDS and sex. [PROMPT: What advice do they usually give? About condoms? About not having sex?]

[TRANSITION]: Now that we've talked about a few things you've learned about AIDS so far, I'd also like to hear your general reactions and feelings about AIDS.

---

2. REACTIONS TO AIDS

⇒ I'd like you to guess about how most African American teens feel about AIDS.

As you might know, basketball star Magic Johnson announced several years ago that he was diagnosed with the AIDS virus. Some people believe his announcement encouraged African American teens to practice safer sex or to wait until they're older to have sex.

- I'm curious to hear what you think about Magic Johnson.

- If you ever saw him on TV, how did you react to what he said?

- Not counting famous people like Magic Johnson, can you think of anybody you personally know who has AIDS? If so, how did you meet that person? What feelings or reactions did you have toward that person?

- <u>Imagine</u> that your best friend just told you that he has tested positive for AIDS. What would you say? What would you do? What reactions or feelings might you have?

[TRANSITION]: It's often said that many teenagers believe they are invincible and immune to all harm. This may be true when it comes to AIDS, too. I'd like to talk a little about how teens in Gainesville perceive the spread of AIDS.

---

3. TEENS & AIDS

⇒ I wonder if most African American teens are actually worried or concerned about getting AIDS. [PROMPT: What do you think?]

When people are not concerned enough about getting AIDS, they may make risky choices because they don't realize they're in danger. But when people are too worried, sometimes they might become so afraid of getting AIDS that they just give up and don't try to do anything to protect themselves.

- I'd like to hear your opinions about whether African American teens should be more concerned or less worried about AIDS than they are now.

- I'm interested to know how concerned about AIDS your are, in your own life. [PROMPT: Why do you say that?]

[SUMMARIZE].

According to experts, AIDS is the number one killer of African Americans ages 25 to 44 in America. After a person is infected, it can take 10 years or longer before they can show symptoms and be diagnosed with AIDS. Many African Americans who have died of AIDS became infected when they were your age, through unsafe sex or by using unsterilized needles.

- Obviously, AIDS is a big problem for African Americans nationally, particularly for teens. I'm interested in how you see the situation in Gainesville, by comparison.

[TRANSITION]: Now, I'd like to shift from what's going on in Gainesville to a more personal level. I'm curious to hear about conversations you've had with other people about AIDS.

---

4. TALKING ABOUT AIDS

I'd like us to spend just a moment in silence so you can think of one or two people you remember talking to about AIDS.

$\Rightarrow$ Tell me about those conversations.

> [*OPTIONAL*: Who did you talk to? What kinds of things did you talk about? Why did the subject of AIDS come up in your conversation?]

[SUMMARIZE].

Before we move to the next topic, I wonder if there's anything else you'd like to say about AIDS.

[TRANSITION]: Drinking and using drugs can put kids at risk of getting AIDS. When we're drunk or high, we're more likely to go to bed with somebody without thinking about all the bad things that might happen, like getting infected with AIDS. I'd like to ask you a few questions to get your opinions about drugs and alcohol . . .

DRUG USE   [20-30 minutes]

- What do other teens your age think about drinking?

- I'm curious to know how common drinking is among kids in your school.

- Why do they drink?

- What do most African American teens think about using crack?
  - What about marijuana?
  - Injecting drugs?

- Again, I'm curious about how common it is for kids in your school to use these kinds of drugs.

- Why do they use drugs? [OPTIONAL: What are some reasons?]

- What kind of image or reputation do kids have if they try drugs or drink?

- I'd like to know what you personally think about drinking and about drugs.

- Speaking for yourself, what difference does it really make, whether kids use drugs or not?

- Imagine you're at a party and everyone is either doing drugs or drinking alcohol. What would you do?

[SUMMARIZE].

Is there anything else you'd like to add about drinking or drugs?

[TRANSITION]: We've looked at some of the ways that drugs and alcohol can create risky situations for kids. I think it's especially important for us to talk about sex, since that's the biggest way that teens your age get AIDS. So now, I'd like to talk about your views on sex.

SEX   [30-40 minutes]

1. GENERAL ATTITUDES

- I'm curious to hear what kids your age really think about having sex.

- Why do kids have sex? [PROMPT: How do you feel about those reasons?]

- How can a person know if they're ready to have sex?

- I wonder if you could think of any problems people can have if they have sex.

  [PROMPTS: What are some emotional consequences? What are reasons a person might wait until they're older or married?]

- Why do people get married?

- Why does the church say it's OK to have sex when you're married, but not before then?

[TRANSITION]: It sounds like you have thought about some of these reasons or that you've heard about these things in school or church. But I'm also interested to hear about how you talk about sex with your friends in more everyday situations, like when you're talking at the mall or on the phone.

---

2. TALKING ABOUT SEX WITH FRIENDS

- I'd like you to think about some actual conversations you've had with your friends about sex or relationships. Tell me about those conversations.

  [PROMPT: What started those conversations?]

- If a boy came to one of his friends, and said he was thinking about having sex, what would the friend probably say to him?

  [PROMPT: What are some other ways a friend <u>could</u> react?]

- Now, if one of your close friends came to you and asked whether or not he should have sex, what advice would you probably give him?

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- Imagine that one of your friends is having sex. He tells you, "You've got to try it!" What would you say?

- How would he probably react if you told him to stop having sex and then wait until he's older or married to start having sex again? How would you react if a friend said that to you?

[TRANSITION]: Now that we've discussed how teens usually talk about sex, I'd also like to hear about how you might talk with adults about sex-related issues in your own life.

---

3. **TALKING ABOUT SEX WITH ADULTS**

- Suppose you were dealing with a problem or a question about relationships or sex, and you wanted to talk to someone. What would you do?

- I'm curious about whether there are any people besides your friends you might talk to?

- Other than your friends, who would be your favorite person to talk to about these kinds of issues? Why? Who would be your least favorite person to talk to? Why?

- I'm curious about whether you ever talk about sex or relationships with your parents. [PROMPT: What do you talk about with them? What kinds of advice do they give you?]

[TRANSITION]: Next, I'd like to talk about a couple of imaginary situations, so that I can hear your ideas about how you might deal with each of them.

---

4. **HYPOTHETICAL SITUATIONS**

- Imagine you're at a concert and a cute woman in her 20s asks you to go home with her. What do you do?

- Let's say you just met a girl who's really fine looking, and you wanted to see if she might be interested in you, too. What would you be willing to do to get her to be your girl friend?

- Now suppose your friends tried to get you to go after her right away and dared you to see how far you could get with her. How would you probably react to them?

- Imagine that you just started going with a girl at school. Then, after a short time, she says she wants to have sex. How would you probably react? [PROMPT: How would you decide about what you'd actually be willing to do or not do?]

- Imagine you're playing basketball with your friends. Everyone tells their story about having sex, but you're a virgin. What would you tell them?

[SUMMARIZE]. Before we move on to the next topic, I'd like to hear anything else you'd like to say about sexual issues.

[TRANSITION]: I'm sure your minister and other people in your church have views about all the topics we've been talking about. I am interested in what you think they would have to say about some of these things.

RELIGIOUS VIEWS OF AIDS   [15-20 minutes]

1. **HYPOTHETICAL VIDEO**

- I'm curious about how your minister and other people in your church might react to the video you saw today.

- Imagine that one day your church is going to make a video that would tell kids how to avoid getting AIDS. I'd like to hear your thoughts about how they would probably go about doing this. [PROMPTS: How would the video probably be different from the video we saw today? How would it be similar?]

- What if your church made a video about using drugs? How would they talk about this?

[TRANSITION]: For a moment now, I'd like to hear your general views about church.

---

2. **RELIGIOSITY**

- I'm interested to hear about how important church is in the lives of most African American teens, compared with white teens.

- How often should teens go to church? [PROMPT: Why do you say that?]

- Let's imagine that I've never been to church before, and I came to you for some advice about how to become a good Christian. What advice would you give me?

- Many people who go to church do not agree with everything the minister preaches. I'm interested in hearing about things you've been taught in church that you don't like or totally agree with.

[TRANSITION]: Now, getting back to the subject of sex, I'm curious to hear a little about how your church usually deals with topics like sex and AIDS.

3. **RELIGIOUS TALK ABOUT SEX**

- I'd like to know how your minister or other church leaders usually talk about sex or relationships.

[PROMPTS: What do you think about their advice? Why?]

- I'm curious to know if going to church or being a good Christian can affect the way a person thinks or talks about AIDS or sex.

[PROMPT: For instance, I wonder if it is OK for a good Christian to have sex before marriage. Why do you say that?]

- Imagine that you went to church one day, and your minister or youth leader invited you to go for a walk. He said he wanted to be available to you if you ever had any questions or problems. Then he said you could ask him absolutely anything you wanted about sex or AIDS, and promised to keep the conversation confidential. I'm curious to hear about one thing you might say or ask him, if you had that opportunity.

[PROMPT: How would you feel if you were in this situation?]

[SUMMARIZE].

WRAP-UP   [5-10 minutes]

We've covered a lot of ground today. I'm going to read through a list of the topics we've discussed today, to give you one last chance to say anything else you think is important.

CHECKLIST OF TOPICS

[MODERATORS: Read items on checklist, then give them a chance to comment.]

___ **REACTIONS TO THE VIDEO**

___ **AIDS**
1. AIDS knowledge
2. Reactions to AIDS
3. Personal concerns about AIDS
4. Talking about AIDS

___ **DRUGS AND ALCOHOL USE**

___ **SEX**
1. General attitudes about sex
2. Talking about sex with friends
3. Talking about sex with adults

___ **RELIGIOUS VIEWS**
1. Being a good Christian
2. Religious views of sex and AIDS

Are there any final comments you'd like to add about any of these topics?

Thanks. I really appreciate your help. Again, I'd ask that you respect the confidentiality of other people's comments from today's discussion.

Moderator_____

Date_____

Place_____

Start time _____   Ending time_____

Group type (check one):   ____ Girls   ____ Boys

Number participants in focus group_____

YOUTH ASSENT SCRIPT

My name is _____, and I am a student at
_____. I am working as a research assistant on a project for
Kristie Swain. Kristie is a doctoral student at the University of Florida.

If it's OK with you, I will ask you and your friends a few questions about AIDS issues. I
cannot give you money or prizes for talking with me. Your views about AIDS are very
important because your ideas and opinions could help us find ways to save other kids
from getting AIDS. You may benefit from this project by learning about things you can
do to help slow the spread of AIDS in our community.

I will be tape recording this discussion, but only those who are conducting this project
will have access to these tapes. Your name will not be included in the report about this
project. I won't tell your teacher or family or friends anything you say today in this
group.

You do not have to answer any question you do not want to answer. You can withdraw
from the group any time. If you have any questions, please ask me.

INTRODUCTION

I will be leading the group discussion today, and it will last between an hour to an hour
and a half. Afterwards, we will have a pizza party.

Today we will focus on what you think about AIDS and some issues related to AIDS like
drugs and sex. Your views are important to me because I'm interested to learn more
about how kids your age think about AIDS. Your opinions may be used to make a
booklet that could help save other kids from getting AIDS.

I am not here to provide information to you or to present a point of view. I simply want
to find out what you think. From my point of view, there are no right or wrong answers –
just opinions, feelings, and reactions. I want to hear those from you.

GROUND RULES

First of all, I'd like to set up a few basic ground rules for our discussion:

1. I can guarantee my confidentiality and that of the tapes, but of course I can't guarantee yours. So I'm asking you to agree to not repeat others' comments from today to anyone else. This will make it easier for all of us to talk openly.

2. I'm going to ask that only one person talk at a time, so I can hear each of your ideas and so everybody gets a chance to have a say in our discussion. Everyone will have the chance to participate. When someone is talking, I would ask that everyone else be very quiet.

3. Please raise your hand whenever you want to say something. When several people want to respond at the same time, I will call on you randomly.

4. On some of the topics we'll talk about, it's natural for people to have different points of view and maybe even disagreements. I am interested in ALL of your ideas, whether they are the same or different from those of others. Feel free to say you disagree, if you do. But I want you to give each other the time to talk and listen to each other with respect.

MODERATORS:
Reminders about reflective listening

After asking major open questions, or before moving to a new topic, remember to summarize the topic discussion by restating one or two of the most important views that were said about that topic. Whenever you see the cue [SUMMARIZE], use your judgment about whether to make a summary statement before moving on – if the discussion needs closure because various views have been expressed or because you need to re-focus the discussion, etc.)

To SUMMARIZE, use a reflective listening (mirroring) statement. Start it by saying something like:

υ "It sounds like you are saying that…"   υ "What you seem to be saying is that . . ."
υ "What I hear you saying is that . . ."   υ "You are worried that . . ."
υ "Some of you seem to be saying . . ., while some of you seem to feel that . . ."

After you SUMMARIZE, give the kids a chance to elaborate on or clarify your summary before you move on to a new set of questions.

⇒ These are **KEY questions** (the ones you might spend more time talking about).

INTRODUCTIONS   [5 minutes]
I'd like you to introduce yourself by your first name, your age, and what you would like
to do after you graduate from high school.

LEAD-IN: Today, we will be discussing five different AIDS-related topics.
I'd like to get started with your overall reactions to the video we just watched.

REACTIONS TO VIDEO   [15-20 minutes]

⇒ I'm interested in what you liked or disliked about the video.

- What are your feelings about it?

- I wonder if you think the boys in the other group would react differently than you
  did. [PROMPT: How?]

- Some people might think this video is realistic, while others might think it's not.
  I'd like to hear your reactions.

- How are the people in the video like people you know? How are they different?

- Are any of the characters similar to you? [PROMPT: If so, how?]
  How are they different from you?

⇒ What is the moral or overall lesson of the story?

υ [SUMMARIZE].

OK, before we move on, I want to see if there's anything else you'd like to say about
your reactions to the video.

[TRANSITION]: As you saw in the video, AIDS has become an important issue for
African American teens today. I am interested in finding out how teens like yourselves
think about AIDS, in general.

AIDS – IN GENERAL   [40-45 minutes]

⇒ What do you think of when you hear the word "AIDS"? I'd like to hear your feelings or reactions.

1. AIDS KNOWLEDGE

• I'm curious about what you've heard about where AIDS comes from.

• How did AIDS get started?

  [*OPTIONAL*: Some people say that somebody created AIDS to kill people in Africa. Have you ever heard that? I'm curious to know what you think.]

• I'd like to hear some different ways that a person can get AIDS.

• How can you tell if somebody has AIDS?

• Among your family, friends, and kids you know at school or church, can you think of anybody who is probably not at risk of getting AIDS? [FOLLOW-UP: Why are they are safe from getting AIDS?]

• I'd like you to think back over the last few years, about where you remember getting the most information about AIDS. [PROMPT: From school, your friends, TV, or from some other place?]

• I've heard that teachers at school sometimes give advice about AIDS and sex.

  [PROMPT: What advice do they usually give? About condoms? About not having sex?]

[TRANSITION]: Now that we've talked about a few things you've learned about AIDS so far, I'd also like to hear your general reactions and feelings about AIDS.

---

2. REACTIONS TO AIDS

⇒ I'd like you to guess about how most African American teens feel about AIDS.

As you might know, basketball star Magic Johnson announced several years ago that he was diagnosed with the AIDS virus. Some people believe his announcement encouraged African American teens to practice safer sex or to wait until they're older to have sex.

• I'm curious to hear what you think about Magic Johnson.

• If you ever saw him on TV, how did you react to what he said?

• Not counting famous people like Magic Johnson, can you think of anybody you personally know who has AIDS? If so, how did you meet that person? What feelings or reactions did you have toward that person?

- <u>Imagine</u> that your best friend just told you that she has tested positive for AIDS. What would you say? What would you do? What reactions or feelings might you have?

[TRANSITION]: It's often said that many teenagers believe they are invincible and immune to all harm. This may be true when it comes to AIDS, too. I'd like to talk a little about how teens in Gainesville perceive the spread of AIDS.

---

3. TEENS & AIDS

⇒ I wonder if most African American teens are actually worried or concerned about getting AIDS. [PROMPT: What do you think?]

When people are not concerned enough about getting AIDS, they may make risky choices because they don't realize they're in danger. But when people are too worried, sometimes they might become so afraid of getting AIDS that they just give up and don't try to do anything to protect themselves.

- I'd like to hear your opinions about whether African American teens should be more concerned or less worried about AIDS than they are now.

- I'm interested to know how concerned about AIDS your are, in your own life. [PROMPT: Why do you say that?]

υ [SUMMARIZE].

According to experts, AIDS is the number one killer of African Americans ages 25 to 44 in America. After a person is infected, it can take 10 years or longer before they can show symptoms and be diagnosed with AIDS. Many African Americans who have died of AIDS became infected when they were your age, through unsafe sex or by using unsterilized needles.

- Obviously, AIDS is a big problem for African Americans nationally, particularly for teens. I'm interested in how you see the situation in Gainesville, by comparison.

[TRANSITION]: Now, I'd like to shift from what's going on in Gainesville to a more personal level. I'm curious to hear about conversations you've had with other people about AIDS.

---

4. TALKING ABOUT AIDS

I'd like us to spend just a moment in silence so you can think of one or two people you remember talking to about AIDS.

663

⇒ Tell me about those conversations.

[*OPTIONAL*: Who did you talk to? What kinds of things did you talk about? Why did the subject of AIDS come up in your conversation?]

υ [SUMMARIZE].

Before we move to the next topic, I wonder if there's anything else you'd like to say about AIDS.

[TRANSITION]: Drinking and using drugs can put kids at risk of getting AIDS. When we're drunk or high, we're more likely to go to bed with somebody without thinking about all the bad things that might happen, like getting infected with AIDS. I'd like to ask you a few questions to get your opinions about drugs and alcohol . . .

DRUG USE   [20-30 minutes]

- What do other teens your age think about drinking?

- I'm curious to know how common drinking is among kids in your school.

- Why do they drink?

- What do most African American teens think about using crack?
    - What about marijuana?
    - Injecting drugs?

- Again, I'm curious about how common it is for kids in your school to use these kinds of drugs.

- Why do they use drugs? [OPTIONAL: What are some reasons?]

- What kind of image or reputation do kids have if they try drugs or drink?

- I'd like to know what you personally think about drinking and about drugs.

- Speaking for yourself, what difference does it really make, whether kids use drugs or not?

- Imagine you're at a party and everyone is either doing drugs or drinking alcohol. What would you do?

υ [SUMMARIZE].

Is there anything else you'd like to add about drinking or drugs?

[TRANSITION]: We've looked at some of the ways that drugs and alcohol can create risky situations for kids. I think it's especially important for us to talk about sex, since that's the biggest way that teens your age get AIDS. So now, I'd like to talk about your views on sex.

SEX   [30-40 minutes]

1. **GENERAL ATTITUDES**
- I'm curious to hear what kids your age really think about having sex.

- Why do kids have sex? [PROMPT: How do you feel about those reasons?]

- How can a person know if they ready to have sex?

- I wonder if you could think of any problems people can have if they have sex.
  [PROMPTS: What are some emotional consequences? What are reasons a person
  might wait until they're older or married?]

- Why do people get married?

- Why does the church say it's OK to have sex when you're married, but not before
  then?

[TRANSITION]: It sounds like you have thought about some of these reasons or that
you've heard about these things in school or church. But I'm also interested to hear
about how you talk about sex with your friends in more everyday situations, like when
you're talking at the mall or on the phone.

2. **TALKING ABOUT SEX WITH FRIENDS**
- I'd like you to think about some actual conversations you've had with your friends
  about sex or relationships. Tell me about those conversations.

  [PROMPT: What started those conversations?]

- If a girl came to one of her girl friends, and said she was thinking about having sex,
  what would the friend probably say to her?

  [PROMPT: What are some other ways a friend could react?]

- Now, if one of your close friends came to you and asked whether or not she should
  have sex, what advice would you probably give her?

- Imagine that one of your friends is having sex. How would she probably react if you
  told her to stop having sex and then wait until she's older or married to start having
  sex again? How would you react if she said that to you?

[TRANSITION]: Now that we've discussed how teens usually talk about sex, I'd also
like to hear about how you might talk with adults about sex-related issues in your own
life.

3. TALKING ABOUT SEX WITH ADULTS

- Suppose you were dealing with a problem or a question about relationships or sex, and you wanted to talk to someone. What would you do?

- I'm curious about whether there are any people besides your friends you might talk to?

- Other than your friends, would be your favorite person to talk to about these kinds of issues? Why? Who would be your least favorite person to talk to? Why?

- I'm curious about whether you ever talk about sex or relationships with your parents.

  [PROMPT: What do you talk about with them? What kinds of advice do they give you?]

[TRANSITION]: Next, I'd like to talk about a couple of imaginary situations, so that I can hear your ideas about how you might deal with each of them.

4. HYPOTHETICAL SITUATIONS

- Imagine you're at the mall and you see the guy you like talking to a girl whose skirt is so short it barely covers her rear-end. Your friends say if you want the guy to notice you, you'll have to wear revealing clothing. What do you do?

- Let's say you just met a guy who's really fine looking, and you wanted to see if he might be interested in you, too. What would you be willing to do to get him to be your boy friend?

- Now suppose your friends tried to get you to go after him right away and dared you to see how far you could get with him. How would you probably react to them?

- Imagine that you just started going with somebody at school. Then, after a short time, he says he'd like to have sex. How would you probably react?
  [PROMPT: How would you decide about what you'd actually be willing to do or not do?]

- Your friends say if you've been going with your boyfriend for 3 months and you still haven't had sex, something's wrong. What do you tell them?

υ [SUMMARIZE].

Before we move on to the next topic, I'd like to hear anything else you'd like to say about sexual issues.

[TRANSITION]: I'm sure your minister and other people in your church have views about all the topics we've been talking about. I am interested in what you think they would have to say about some of these things.

RELIGIOUS VIEWS   [15-20 minutes]

1. HYPOTHETICAL VIDEO

- I'm curious about how your minister and other people in your church might react to the video you saw today.

- <u>Imagine</u> that one day your church is going to make a video that would tell kids how to avoid getting AIDS. I'd like to hear your thoughts about how they would probably go about doing this.

  [PROMPTS: How would the video probably be different from the video we saw today? How would it be similar?]

- <u>What if</u> your church made a video about using drugs? How would they talk about this?

[TRANSITION]: For a moment now, I'd like to hear your general views about church.

---

2. RELIGIOSITY

- I'm interested to hear about how important church is in the lives of most African American teens, compared with white teens.

- How often should teens go to church? [PROMPT: Why do you say that?]

- Let's <u>imagine</u> that I've never been to church before, and I came to you for some advice about how to become a good Christian. What advice would you give me?

- Many people who go to church do not agree with everything the minister preaches. I'm interested in hearing about things you've been taught in church that you don't like or totally agree with.

[TRANSITION]: Now, getting back to the subject of sex, I'm curious to hear a little about how your church usually deals with topics like sex and AIDS.

3. RELIGIOUS TALK ABOUT SEX AND AIDS

- I'd like to know how your minister or other church leaders usually talk about sex or relationships.

  [PROMPTS: What do you think about their advice? Why?]

- I'm curious to know if going to church or being a good Christian can affect the way a person thinks or talks about AIDS or sex.

  [PROMPT: For instance, I wonder if it is OK for a good Christian to have sex before marriage. Why do you say that?]

- <u>Imagine</u> that you went to church one day, and your minister or youth leader invited you to go for a walk. She said she wanted to be available to you if you ever had any questions or problems. Then she said you could ask her absolutely anything you wanted about sex or AIDS, and promised to keep the conversation confidential. I'm curious to hear about one thing you might say or ask her, if you had that opportunity.

  [PROMPT: How you feel if you were in this situation?]

υ [SUMMARIZE].

WRAP-UP [5-10 minutes]

We've covered a lot of ground today. I'm going to read through a list of the topics we've discussed today, to give you one last chance to say anything else you think is important.

CHECKLIST OF TOPICS

[MODERATORS: Read items on checklist, then give them a chance to comment.]

____ **REACTIONS TO THE VIDEO**

____ **AIDS**
1. AIDS knowledge
2. Reactions to AIDS
3. Personal concerns about AIDS
4. Talking about AIDS

____ **DRUGS AND ALCOHOL USE**

____ **SEX**
1. General attitudes about sex
2. Talking about sex with friends
3. Talking about sex with adults

____ **RELIGIOUS VIEWS**
1. Being a good Christian
2. Religious views of sex and AIDS

Are there any final comments you'd like to add about any of these topics?

Thanks. I really appreciate your help. Again, I'd ask that you respect the confidentiality of other people's comments from today's discussion.

[PIZZA PARTY!!!]

Moderator_____

Date_____

Place _____

Start time _____   Ending time_____

Group type (check one):   ____ Girls   ____ Boys

Number participants in focus group_____

Youth Assent Script

My name is _____, and I am a student at _____.
I am working as a research assistant on a project for Kristie Swain. Kristie is a doctoral
student at the University of Florida.

If it's OK with you, I will ask you and your friends a few questions about AIDS issues.
I cannot give you money or prizes for talking with me. Your views about AIDS are very
important because your ideas and opinions could help us find ways to save other kids
from getting AIDS. You may benefit from this project by learning about things you can
do to help slow the spread of AIDS in our community.

I will be tape recording this discussion, but only those who are conducting this project
will have access to these tapes. Your name will not be included in the report about this
project. I won't tell your teacher or family or friends anything you say today in this
group.

You do not have to answer any question you do not want to answer. You can withdraw
from the group any time. If you have any questions, please ask me.

INTRODUCTION

I will be leading the group discussion today, and it will last about an hour. Afterwards,
we will have some snacks. Today, we will focus on what you think about AIDS and
some issues related to AIDS like drugs and sex. Your views are important to me because
I'm interested to learn more about how kids your age think about AIDS.

I am not here to provide information to you or to present a point of view. I simply want
to find out what you think. From my point of view, there are no right or wrong answers –
just opinions, feelings, and reactions. I want to hear those from you.

GROUND RULES

Before we start, I'd like to set up a few basic ground rules for our discussion:

1. I can guarantee my confidentiality and that of the tapes, but of course I can't guarantee yours. So I'm asking you to agree to not repeat others' comments from today to anyone else. This will make it easier for all of us to talk openly.

2. I'm going to ask that only one person talk at a time, so I can hear each of your ideas and so everybody gets a chance to have a say in our discussion. Everyone will have the chance to participate. When someone is talking, I would ask that everyone else be very quiet.

3. Please raise your hand whenever you want to say something. When several people want to respond at the same time, I will call on you randomly.

4. On some of the topics we'll talk about, it's natural for people to have different points of view and maybe even disagreements. I am interested in ALL of your ideas, whether they are the same or different from those of others. Feel free to say you disagree, if you do. But I want you to give each other the time to talk and listen to each other with respect.

INTRODUCTION TO THE *FOTONOVELA*

[LEAD-IN]: Today, I will be asking each of you to be an editor, to help us fix and improve a story booklet that you helped us make. Later on, we will talk about how you can help your friends learn more about AIDS using this booklet.

> **MODERATORS: Give each person <u>one</u> blank envelope.**

First, I'd like you to write your name on the front of this envelope. Later on, I'll explain what this envelope is for.

Today, I am appointing you to be a special board of editors, kind of like the people who proofread and publish the *Gainesville Sun* or *Essence* magazine. I am putting you in charge of giving me advice to help us improve the story booklet that some of you helped us make last week. Your ideas about this booklet are very important to me. What you say today will be taken very seriously.

We will be printing copies of this booklet to give out to hundreds of other African American kids. But first, we need to find out whether you think it is interesting and helpful to read and get your advice about how to fix it.

This booklet contains pictures of some of you and parts of the skits that some of you wrote last week. While we are talking today, I want you to remember that your job is to be an editor and to give me advice about how to make this booklet better than it is now. I need you to think very seriously about how other African American kids will react to this booklet. The things you say today will help shape how it turns out.

It is very important for me to find out what you like and don't like about the booklet, what you think is good or bad, and what you think needs to be fixed or changed. So, today I'm going to ask you some questions about the booklet that will help you in your job as editors.

> **MODERATORS: Collect all envelopes. Give each person _one_ booklet.**

Now, I'll give you a few minutes to read this booklet. I'd like you to be very quiet so everyone will be able to read this. In a few minutes, I will give everyone a chance to talk about it.

[TRANSITION]: We'll get started with your overall reactions to this booklet.

> **MODERATORS: *****BEGIN TAPE RECORDER*****

GENERAL REACTIONS

- I'd like to know what you thought was the best thing about this, what you liked the most about it?

- I'm interested to hear what you thought was the worst thing, or what you liked the least about it?

- I wonder if you think the girls/boys in the other group would react differently than you did. [PROMPT: How?]

[SUMMARIZE].

[TRANSITION]: Now, I'd like to ask you about the people in the story and your reactions to them.

THE CHARACTERS

- How are the people in the booklet like people you know? [PROMPTS: What about Kevin? Josh? Samantha? Tatiana?]

- How are they different from people you know?

- I wonder if any of the characters are similar to <u>you</u>? [PROMPT: If so, how?]

- How are they different from <u>you</u>?

[SUMMARIZE].

[TRANSITION]: Now that we've talked about these characters, I'd like for us to talk about how the story compares with real life.

REALISM

- Some people might think this story is realistic, while others might think it's not. I'd like to hear your reactions.

- I'm curious if any of the situations in the story have happened to people you know.

[SUMMARIZE].

[TRANSITION]: Next, I'd like to talk about the message of this story.

THE MESSAGE

- I'd like you to tell me the most important things you learned from the story.

- What is the moral or overall lesson of the story?

- I wonder if the lesson of the story could be different? What kind of lesson would you use?

[SUMMARIZE].

- OK, before we move on, I want to see if there's anything else you'd like to say about your reactions to the story.

[TRANSITION]: I appreciate hearing your reactions to the story. Since you are my editors today, I also want to ask you a few questions about different aspects of the booklet. I want you to tell me, straight out, what you don't like about this booklet, and how you think we should fix it. I also want to hear what you <u>do</u> like and would keep.

[TRANSITION]: First, I'm going to ask you some questions about how the booklet looks.

THE BOOKLET

APPEARANCE

- I'm curious to hear how you think the booklet looks.

- What is your favorite thing about the way it looks?

- What is the worst thing about the way it looks? How would you fix it?

- What do you think about the size of it?

- What do you like best/most about the photos?

- Which pictures are your favorites? Why?

- Which pictures do you like the least? Why?

- What do you think about the lettering?

[SUMMARIZE].

[TRANSITION]: As you might remember, this booklet is supposed to be designed for African American kids your age. So, I'm interested to learn about your reactions, plus I want to know what your friends will probably think about the booklet. I'm especially curious about what kids might think about how easy or hard it is to read this booklet, words that might be confusing, and slang words that could be used.

LANGUAGE

- I'm curious if you saw any words or sentences or other parts of the story that might be hard to understand or confusing.

- I wonder if you can find any words that seem out of place? [PROMPT: Some kids might think that some words are unfamiliar, cheesy, or offensive.]

- What are some slang words or rhyming words that we could add to make it more interesting or real?

- What do you think about using rap in this booklet?

- I wonder if you know anybody who doesn't know enough about AIDS to understand this story? How would they probably react to it?

[SUMMARIZE].

[TRANSITION]: Next, I'd like to talk about your reactions to the story's messages about AIDS.

REACTIONS TO THE STORY

- I want to know the kinds of moods the story put you in when you read it.

- I'm interested to know if you think any parts of the story are funny? Scary? [PROMPTS: Which parts are you talking about?]

- How interesting was the story to you? Why?

- I wonder why your friends will be interested in reading this?

- Some kids might say this story is too serious or boring or goody-goody. What do you think?

[SUMMARIZE].

[TRANSITION]: Next, I'd like you to think about things kids could learn from reading this. I also want to get more of your advice about what you think is good and what needs to be fixed.

THE LESSON OF THE STORY

- First, I'd like you to tell me the main things your friends will probably learn from this story?

- I'm interested to know if you learned anything new about AIDS from the information on the back.

- I wonder if you can think of any other information about AIDS that should be included.

- If you could change any part of this story, what would you change? [PROMPTS: How would you change it? What are some other stories, characters, situations we could write about?]

- I'm interested to hear any other ideas you'd like to add about the story or the booklet.

[SUMMARIZE].

[TRANSITION]: You've given me some good advice about how to make the booklet and story better.

[TRANSITION]: We've come here to talk with you during the last couple of weeks because we heard that many of you are very involved in the community, in your school, and in your churches.

We're looking for African American teens like you who can help us teach other kids about the dangers of AIDS. Now we want you to help us with a very important project this week. We want you to give copies of this story booklet to your friends and ask them to read it.

You've helped me as an editor today, and now I want you to shift gears for a moment. I'd like you to think of yourself as a helpful friend – someone who cares about whether your friends know about risks from AIDS and having sex. I am interested in finding out how you might talk to your friends about AIDS.

SHARING THE BOOKLET

- Some people might think it's hard to share this booklet or talk about AIDS with their friends. I'm interested to know how you feel about doing this?

- I'd like to make a list of things you could say to friends when you first hand them a copy of the booklet.

  [PROMPT (role playing): Pretend I am a friend at school, and you are about to give me a booklet.]

- Do you think that will be hard to do? [PROMPT: In what ways?]

- Some kids might feel embarrassed or mad about being asked to talk about this booklet. How would you feel if somebody handed you this booklet?

- What are some good things you could say to start a conversation with somebody? What kinds of things would not work very well?

- Imagine that you just gave a friend this booklet and all he/she wanted to do is joke around. You can't get a straight answer about what he/she really thinks. What would you do?

- OK, so your goal will be to talk to your friends about AIDS or sex, not just hand them a booklet. Do you think that will be hard to do? Why?

- I'd like you to think to yourself for a moment about 5 friends you could give this booklet to this week. How will you pick the friends you give the booklet to?

- I'd like you to think of some places where it would be easier to show your friends this booklet and talk about it.

[SUMMARIZE].

WRAP-UP

Now, I'm going to read through a list of the things we've talked about today, to give you one last chance to say anything else you think is important.

CHECKLIST

[Read items on checklist, then give them a chance to comment.]

____ **GENERAL REACTIONS TO THE STORY**
1. What you liked/disliked about it
2. If the story is realistic
3. The lesson of the story

____ **EVALUATION OF THE BOOKLET**
1. How it looks
2. Hard or confusing words
3. Slang and rap
4. Mood of the story
5. Things people can learn from it
6. Other ideas

____ **SHARING THE BOOKLET WITH YOUR FRIENDS**

- Are there any final comments you'd like to add about any of these topics?

MODERATORS: *** TURN OFF TAPE RECORDER *****

Just as a reminder, I ask that you respect the confidentiality of other people's comments from today's discussion. In just a moment, Kristie will give you a booklet kit that you can use this week when you talk to your friends about AIDS.

MODERATORS: Give Kristie the cassette tapes and recorder. Kristie will now talk to your group (boys or girls) for a few minutes, to give them their booklets and other materials.

INSTRUCTIONS   [from Kristie]

[TRANSITION]: Now that we've talked about some different ways that you can share the story booklet with your friends, I'd like to give you a little kit to get you started.

I'm going to give you your envelope back with 5 copies of the story booklet inside it. You need to put your own copy inside the envelope, too. I want you to give a copy of the booklet to 5 of your friends this week. Make sure you keep one copy for yourself.

Whenever you give a booklet to a friend, I'd like you to do 4 things:

1. Ask them to read the booklet.
2. After they've finished reading it, ask them for their reactions to it.
3. Listen carefully, and remember what they say. It might help to take notes about what they tell you, so it will be easier for you to talk about it when we meet next week.
4. Ask them to sign your list (inside the envelope).

We'll meet again next Monday to talk about your conversations with your friends. I'd like you to bring your list on Monday, so you can remember who you talked to.

A special certificate will be awarded to everybody who gets 5 friends to read the booklet and gets all 5 of them to sign their list. The only friends who don't count are kids who attend this after-school program. I'd like you to give a booklet to your friends in church, or at school, or in your neighborhood, or from your family.

If you need extra copies later this week, just ask Rene, Lenee, or co-pastor King. If you end up with extras that you don't need, please give them back to one of the youth leaders so other kids can use them. I am trusting you to keep track of these booklets. I just ask that you do not throw any booklets away or lose them.

[Give each child his/her envelope/kit.]

You need to put your own booklet inside the envelope, now.

Thanks for your advice and help with this project. I really appreciate your help, and I'm looking forward to hearing about what your friends have to say when we talk again on Monday.

In a few moments, we'll have a snack.

APPENDIX B-4
YOUTH FOCUS GROUP DISCUSSION GUIDE #3

Moderator_____
Date_____
Place_____
Start time _____   Ending time_____
Group type (check one):   ____ Girls   ____ Boys
Number participants in focus group_____

Youth Assent Script

My name is _____, and I am a student at _____.
I am working as a research assistant on a project for Kristie Swain. Kristie is a doctoral
student at the University of Florida.

If it's OK with you, I will ask you and your friends a few questions about AIDS issues. I
cannot give you money or prizes for talking with me. Your views about AIDS are very
important because your ideas and opinions could help us find ways to save other kids
from getting AIDS. You may benefit from this project by learning about things you can
do to help slow the spread of AIDS in our community.

I will be tape recording this discussion, but only those who are conducting this project
will have access to these tapes. Your name will not be included in the report about this
project. I won't tell your teacher or family or friends anything you say today in this
group.

You do not have to answer any question you do not want to answer. You can withdraw
from the group any time. If you have any questions, please ask me.

INTRODUCTION

I will be leading the group discussion today, and it will last about an hour. Afterwards,
we will have some snacks. Today, we will focus on what you think about AIDS and
some issues related to AIDS like drugs and sex. Your views are important to me because
I'm interested to learn more about how kids your age think about AIDS.

I am not here to provide information to you or to present a point of view. I simply want
to find out what you think. From my point of view, there are no right or wrong answers –
just opinions, feelings, and reactions. I want to hear those from you.

GROUND RULES

Before we start, I'd like to set up a few basic ground rules for our discussion:

1. I can guarantee my confidentiality and that of the tapes, but of course I can't guarantee yours. So I'm asking you to agree to not repeat others' comments from today to anyone else. This will make it easier for all of us to talk openly.

2. I'm going to ask that only one person talk at a time, so I can hear each of your ideas and so everybody gets a chance to have a say in our discussion. Everyone will have the chance to participate. When someone is talking, I would ask that everyone else be very quiet.

3. Please raise your hand whenever you want to say something. When several people want to respond at the same time, I will call on you randomly.

4. On some of the topics we'll talk about, it's natural for people to have different points of view and maybe even disagreements. I am interested in ALL of your ideas, whether they are the same or different from those of others. Feel free to say you disagree, if you do. But I want you to give each other the time to talk and listen to each other with respect.

MODERATORS: Pass out the small pieces of paper and pencils.

Before we get started with the discussion, I'd like you to write on a little piece of paper the number of people you talked to this week about the story booklet. If you didn't talk to anybody, just write zero. It's OK if you didn't talk to anybody – we just want to count the total number of people that read and reacted to the booklet this week, not counting you.

MODERATORS: Collect pieces of paper from all the participants.

*****BEGIN TAPE RECORDER*****

[TRANSITION]: To get started today, I'd like to talk about the kinds of conversations you had about the story booklet with your friends. If you didn't talk to your friends about the booklet, that's OK. I just want to hear from those of you that did talk about it.

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SHARING THE BOOKLET

EXAMPLES OF CONVERSATIONS

- I'd like you to share your own experiences in using the booklet.
  [OPTIONAL: How did your friends react to the booklet?]

- I'd like to hear examples of specific conversations you had about the booklet?

[SUMMARIZE].

[TRANSITION: Next, I'd like to talk about how you made decisions about how to share the booklet.]

YOUR CHOICES

- How did you pick the friends you gave the booklet to? [PROMPT: How did you know them – from church, school, your family, your neighborhood?]

- I'd like to hear about some of the best places where you talked to your friends about this booklet?

  Where were the worst places to talk?

  Can you think of other places where it could be easier to talk about the booklet, if you could do it again in the future?

- I'd like to hear some things you said when you first handed somebody a copy of the booklet?

[SUMMARIZE].

[TRANSITION]: Now, I'm curious to hear about the kinds of things that happened when you first handed people the booklet.

INITIAL REACTIONS

- What were some of your own feelings about talking to your friends about the booklet?

- I wonder if any kids acted embarrassed or shy when you talked with them?

- I'm curious if any of your friends just joked around and did not really say anything about the booklet?

  [PROMPTS: Why do you suppose they acted that way? What did you do?]

- I'm interested to know if it was hard to talk about this booklet with any of your friends?

  [OPTIONAL: Why? I wonder if any other things made it hard or easy to talk about the booklet?]

[SUMMARIZE].

[TRANSITION]: Next, I'd like to hear about the kinds of things you talked about, besides the booklet itself.

TALKING ABOUT AIDS AND SEX

- I'd like to know if any of you talked to your friends about AIDS or sex.

  [PROMPTS: What did you talk about? Was that hard to do? Why?]

- What were the best things you said?

- I'd like you to tell me the kinds of things that did not work as well?

- I'm interested to know if any of your friends asked you questions? If so, what did they ask you about?]

- Based on your conversations, do you think any of them feel worried about getting AIDS?

[SUMMARIZE].

[TRANSITION]: Next, I'd like to hear about your friends' overall reactions to this booklet.

GENERAL REACTIONS

- I'd like to know what your friends thought was the best thing about this booklet, or what they liked the most about it?

- I'm interested to hear what your friends did not like about it?

- I wonder why some friends were more interested in the booklet than others?

- I'm curious to hear what they thought about how the booklet looks.

- What did they think about using rap in this booklet?

- I'm curious if you heard anybody suggest any changes or improvements of the booklet. Did they offer any ideas?

- I'm interested to know if they learned anything new about AIDS from the information in the booklet.

- I wonder if anybody didn't know enough about AIDS to understand this story?

[SUMMARIZE].

[TRANSITION]: Next, I'd like to talk about your friends' reactions to the story.

REACTIONS TO THE STORY

- I'm interested to know what kinds of moods the story put your friends in when they read it.

- What did your friends say about the people in the booklet?
  [PROMPTS: What about Kevin? Josh? Samantha? Tatiana?]

- I wonder if your friends thought the story was realistic?

- I'm interested to know the most important things they learned from the story.

[SUMMARIZE].

FUTURE DISTRIBUTION OF THE BOOKLET

- I wonder if your friends would like to give copies of the booklet to their friends, too?

- I'd like to hear any ideas of how we could distribute copies of this booklet in the community?

- Beside using this booklet, can you think of other ways that we could teach kids about AIDS prevention?

[SUMMARIZE].

WRAP-UP

Now, I'm going to read through a list of the things we've talked about today, to give you one last chance to say anything else you think is important.

```
                        CHECKLIST

      [MODERATORS: Read items on checklist,
      then give them a chance to comment.]

      SHARING THE BOOKLET
      ___Examples of your conversations
      ___How you chose who to talk to and where
      ___Any problems you had
      ___How you talked about AIDS and sex

      REACTIONS
      ___How your friends reacted to the booklet
      ___What they thought about the story
      ___Ideas of how to distribute the booklet
```

• Are there any final comments you'd like to add about any of these topics?

MODERATORS: *** TURN OFF TAPE RECORDER *****

Just as a reminder, I ask that you respect the confidentiality of other people's comments from today's discussion. This is our last discussion group about AIDS prevention.

I want to thank you for all of your help in this project. If you think of anything else you'd like to talk about, later on, please tell co-pastor King and she will put you in touch with Kristie.

MODERATORS: Give Kristie the tapes and recorder...

WOMEN'S GROUP DISCUSSION GUIDE #1

Moderator_____

Date_____

Place _____

Start time _____ Ending time_____

Number participants in your focus group_____

MODERATOR:

1. Tell the women in your group to take 2 consent forms.
2. Pass a cup of pens/pencils to those who need one.
3. Read entire form out loud, while they read along.
4. Tell them to "Keep one form for yourself."
5. Collect all signed forms after the women have signed them.

Before we get started today, I'd like to make a phone list. This list is also confidential, and we will only use it to keep in touch with you before the next time we meet.

MODERATOR:
1. Pass around a notepad and pen.
2. Have each woman sign her name and phone number.

INTRODUCTION

My name is _____, and I am _____.
I will be leading the group discussion today, and it will last about an hour and a half.
Afterwards, we will have some refreshments.

Today we will focus on what you think about AIDS and some issues related to AIDS like drugs and sex. Your views are important to me because I'm interested to learn more about how African American women think about AIDS and about how they talk to kids about AIDS. Your opinions could help save African American kids from getting AIDS.

I am not here to provide information to you or to present a point of view. I simply want to find out what you think. From my point of view, there are no right or wrong answers – just opinions, feelings, and reactions. I want to hear those from you.

GROUND RULES

First of all, I'd like to set up a few basic ground rules for our discussion:

1. I can guarantee my confidentiality and that of the tapes, but of course I can't guarantee yours. So I'm asking you to agree to not repeat others' comments from today to anyone else. This will make it easier for all of us to talk openly.

2. I'm going to ask that only one person talk at a time, so I can hear each of your ideas and so everybody gets a chance to have a say in our discussion. Everyone will have the chance to participate. When someone is talking, I would ask that everyone else be very quiet so that each person's views can be clearly heard.

3. On some of the topics we'll talk about, it's natural for people to have different points of view and maybe even disagreements. I am interested in ALL of your ideas, whether they are the same or different from those of others. Feel free to say you disagree, if you do. But I want you to give each other the time to talk and listen to each other with respect.

SHOW THE VIDEO
[Kristie will show the "On the Pillow" video, which lasts about 8 minutes.]

INTRODUCTIONS
First, we'll go around the circle, and I'd like you to introduce yourself.

LEAD-IN: Today, we will be discussing five different AIDS-related topics.
I'd like to get started with your overall reactions to the video we just watched.

REACTIONS TO VIDEO

- I'm interested in what you liked or disliked about the video.
  [PROMPT: What are your feelings about it?]

- I wonder if you think kids would react differently than you did.
  [PROMPT: How so?]

- Some people might think this video is realistic, while others might think it's not. I'd like to hear your reactions.

- How are the people in the video like people you know? How are they different?

- Are any of the characters similar to you?
  [PROMPTS: If so, how? How are they different from you?]

- What is the moral or overall lesson of the story?

[SUMMARIZE]. OK, before we move on, I want to see if there's anything else you'd like to say about your reactions to the video.

[TRANSITION]: As you saw in the video, AIDS has become an important issue for African American teens today. I am interested in finding out how women like you think about AIDS, in general.

AIDS – IN GENERAL

- What do you think of when you hear the word "AIDS"? I'd like to hear your feelings or reactions.

1. AIDS KNOWLEDGE

- I'm curious about what you've heard about where AIDS comes from.

- How did AIDS get started?

    [*OPTIONAL*: There are many different theories. Some people say that somebody created AIDS to kill people in Africa. Have you ever heard that? I'm curious to know what you think.]

- I'd like to hear some different ways that a person can get AIDS.

    - How can you tell if somebody has AIDS?

    - Among your family and friends, can you think of anybody who is probably <u>not</u> at risk of getting AIDS?

    [FOLLOW-UP: Why are they safe from getting AIDS?]

- I'd like you to think back over the last few years, about where you remember getting the most information about AIDS.

    [PROMPT: From school, your friends, TV, or from some other place?]

[SUMMARIZE].

[TRANSITION]: Now that we've talked about a few things you've learned about AIDS so far, I'd also like to hear your general reactions and feelings about AIDS.

---

2. REACTIONS TO AIDS

- I'd like you to guess about how most African American women feel about AIDS.

As you might know, basketball star Magic Johnson announced several years ago that he was diagnosed with the AIDS virus. Some people believe his announcement encouraged African American teens to practice safer sex or to wait until they're older to have sex.

- I'm curious to hear what you think about Magic Johnson. If you ever saw him on TV, how did you react to what he said?

- Not counting famous people like Magic Johnson, can you think of anybody you personally know who has AIDS?

  If so, how did you meet that person?

  What feelings or reactions did you have toward that person?

- Imagine that your best friend just told you that she has tested positive for AIDS.

  What would you do?

  What reactions or feelings might you have?

[SUMMARIZE].

[TRANSITION]: As you may know firsthand, many teenagers believe they are invincible from all harm. This is often true when it comes to AIDS. I'd like to talk a little about how African American teens in Gainesville perceive the spread of AIDS.

---

3. TEENS & AIDS

⇒ I wonder if most African American teens are actually worried or concerned about getting AIDS. [PROMPT: What do you think?]

When kids are not concerned enough about getting AIDS, sometimes they make risky choices because they don't realize they're in danger. But when they are too worried, sometimes they become so scared of getting AIDS that they just give up and don't try to do anything to protect themselves.

- I'd like to hear your opinions about whether African American teens should be more concerned or less worried about AIDS than they are now.

- I'm interested to know how concerned about AIDS you are, in your own life. [PROMPT: Why do you say that?]

[SUMMARIZE].

According to experts, AIDS is the number one killer of African Americans ages 25 to 44 in America. After a person is infected, it can take 10 years or longer before they can show symptoms and be diagnosed with AIDS. Many African Americans who have died of AIDS became infected when they were teens, through unsafe sex or by using unsterilized needles.

- Obviously, AIDS is a big problem for African Americans nationally, particularly for teens. I'm interested in how you see the situation in Gainesville, by comparison.

[TRANSITION]: Now, I'd like to shift from what's going on in Gainesville to a more personal level. I'm curious to hear about conversations you've had with other people about AIDS.

---

4. TALKING ABOUT AIDS

Some of you may have talked to someone about AIDS in the past. If so, I'd like you to think of one or two people you remember talking to about AIDS.

⇒ Tell me about those conversations.
   [*OPTIONAL*: Who did you talk to? What kinds of things did you talk about? Why did the subject of AIDS come up in your conversation?]

[SUMMARIZE]. Before we move to the next topic, I wonder if there's anything else you'd like to say about AIDS.

[TRANSITION]: Drinking and using drugs can put kids at risk of getting AIDS. When we're drunk or high, we're more likely to go to bed with somebody without thinking about all the bad things that might happen, like getting infected with AIDS. I'd like to ask you a few questions to get your opinions about drugs and alcohol . . .

DRUG USE

- Out of the kids you know, what do they think about drinking?

- I'm curious to know how common drinking is among black kids. Why do they drink?

- I'm curious about how common it is for black kids in Gainesville to use crack? Marijuana? Heroin? Other drugs?

- Why do they use drugs? [OPTIONAL: What are some of the reasons?]

- What kind of image or reputation do kids have if they try drugs or drink?

- Speaking for yourself, what difference does it really make, whether kids use drugs or not?

- Imagine you have a son or daughter who is at a party, and everybody is doing drugs or drinking alcohol. What would he or she probably do in that situation?

[SUMMARIZE].

Is there anything else you'd like to add about drinking or drugs?

[TRANSITION]: We've looked at some of the ways that drugs and alcohol can create risky situations for kids. I think it's especially important for us to talk about sex, since that's the biggest way that teens get AIDS. So now, I'd like to talk about your views on sex.

SEX

1. GENERAL ATTITUDES

- I'm curious to hear what you think about kids having sex.

- Why do kids have sex? [PROMPT: How do you feel about those reasons?]

- What kinds of things are most girls willing to do or put up with to get a guy to be her boy friend?

- How can a person know if they ready to have sex?

- I wonder if you could think of any problems people can have if they have sex.

  [PROMPTS: What are some emotional consequences? What are reasons a person might wait until they're older or married?]

- Why do people get married?

- Why does the church say it's OK to have sex when you're married, but not before then?

[SUMMARIZE].

[TRANSITION]: It sounds like you've thought about some reasons that kids have sex. But I'm also interested to hear about how you talk about sex with kids in more everyday situations.

---

2. TALKING ABOUT SEX WITH KIDS

- I'd like you to think about some actual conversations you've had with kids – either your kids or other kids you know – about sex or relationships. Tell me about those conversations. [PROMPT: What started those conversations?]

- Suppose a teen told their mother that they were thinking about having sex. How would most African American mothers probably react?

  [PROMPTS: How would most white mothers probably react? What are some other ways a mother could react to her child?]

- Now, if a teen came to you and asked you whether or not they should have sex, what advice would you probably give?

- Imagine that one of your own children told you he or she is having sex. How would they probably react if you told them to stop having sex and then wait until they're older or married to start having sex again?

[SUMMARIZE].

[TRANSITION]: Now that we've discussed how women usually talk about sex with kids, I'd also like to hear about how you talked with adults about sex-related issues when you were growing up.

---

3. TALKING ABOUT SEX , GROWING UP

- Now, I'd like you to think back to when you were a teenager. What did you do when you had a problem or question about relationships or sex?

- Did you ever talk about sex or relationships with your parents? Any other adults? [PROMPT: What do you talk about with them? What kinds of advice did they give you?]

- Can you remember any incidents from your childhood when an older, wiser person really helped you deal with a difficult situation?

[SUMMARIZE].

[TRANSITION]: Next, I'd like to talk about a couple of imaginary situations, so that I can hear your ideas about how you might deal with each of them.

---

4. HYPOTHETICAL SITUATIONS

- Imagine you have a daughter, and she is walking out the door one morning wearing a skirt so short it barely covers her rear-end. What do you do?

- Imagine that your niece has just started going with a boy at school. Then, after a short time, he tells her he wants to have sex. Your niece comes to you for advice. How would you probably react?

- Imagine that church has just ended, and you hear some boys in the corner talking about sex. One boy is telling his friend that if he's been going with a girl for 3 months and he still hasn't had sex with her, something's wrong. What would you do in that situation?

[SUMMARIZE].

Before we move on to the next topic, I'd like to hear anything else you'd like to say about how people talk to kids about sex.

RELIGIOUS VIEWS

1. HYPOTHETICAL VIDEO

- I'm curious about how your minister and other people in your church might react to the video you saw today.

- Imagine that one day your church is going to make a video that would tell kids how to avoid getting AIDS. I'd like to hear your thoughts about how your church would probably go about doing this.

  [PROMPTS: How would their video probably be different from the video we saw today? How would it be similar?]

- What if your church made a video about using drugs? How would they talk about this?

[SUMMARIZE].

[TRANSITION]: For a moment now, I'd like to hear your general views about church.

2. RELIGIOSITY

- I'm interested to hear about how important church is in the lives of most African American teens, compared with white teens.

- What is a good Christian?
  [PROMPT: What kinds of things does a true Christian do?]

- Many people who go to church do not agree with everything the minister preaches. I'm interested in hearing about things you've heard in church that you don't like or totally agree with.

[SUMMARIZE].

[TRANSITION]: Now, getting back to the subject of sex, I'm curious to hear a little about how your church usually deals with topics like sex and AIDS.

3. RELIGIOUS TALK ABOUT SEX AND AIDS

- I'd like to know how your minister or other church leaders usually talk about sex or relationships. [PROMPTS: What do you think about their advice? Why?]

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- I'm curious to know if going to church or being a good Christian can affect the way a person thinks or talks about AIDS or sex.

  [PROMPT: I wonder if it is OK for a good Christian to have sex before marriage. Why do you say that?]

[SUMMARIZE].

[TRANSITION:] We've come here to talk with you today because we heard that many of you are very involved in the community and in your churches. We're looking for African American women like you who can help us teach kids about the dangers of AIDS and unsafe sex.

Now we want you to help us with a very important project this week. We want you to give copies of a story booklet to you that you can use to talk to your own children and other kids that you care about.

I'd like you to think of yourself as a helpful friend – someone who cares about kids and whether they know about risks from AIDS. I am interested in finding out how you might talk to kids about AIDS and sex.

| MODERATOR: Give each woman an envelope containing copies of the booklet. |

Now, I'll give you a few minutes to read this booklet . . .

This booklet contains pictures of kids from Gainesville and parts of skits they wrote about AIDS prevention. In a couple of weeks, we will meet again to find out how kids reacted to the booklet, how you shared it with them, and the kinds of things you said to them.

When we meet again, we will also be asking questions about what you think of the booklet, whether you think it is interesting and helpful to read, and how you might fix it. But today, we will focus on how you can use this booklet to talk to kids.

SHARING THE BOOKLET

- Some women might think it's hard to share this booklet or talk about AIDS with kids. I'm interested to know how you feel about doing this?

- I'd like to make a list of things you could say to kids when you first hand them a copy of the booklet.

  [OPTIONAL PROMPT (role playing): Imagine that I am your daughter or a girl who lives down the street, and you are about to give me a booklet. What would you say to me, to strike up a conversation?]

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- Do you think that will be hard to do? [PROMPT: In what ways?]

- Some kids might feel embarrassed or mad about being asked to talk about this booklet. How would _you_ feel if somebody handed you this booklet?

- What are some good things you could you say to start a conversation with a boy or girl? What kinds of things would not work very well?

- Imagine that you just gave a boy this booklet, and all he wants to do is joke around. You can't get a straight answer about what he really thinks. What would you do?

- I'd like you to think to yourself for a moment about 5 kids you could give this booklet to this week. How would you pick the kids you'd give the booklet to?

- OK, so your goal will be to use this booklet to talk to 5 kids about AIDS or sex, not just hand them a booklet. I wonder if you can think of reasons it might be hard to approach any of these kids?

- I'd like you to think of some private places where it would be easier to talk to kids about this booklet.

- I'd like to hear anything else you'd like to add about approaching kids with this booklet.

[SUMMARIZE].

WRAP-UP

We've covered a lot of ground today. I'm going to read through a list of the topics we've discussed today, to give you one last chance to say anything else you think is important.

> **CHECKLIST OF TOPICS**
>
> [MODERATORS: Read items on checklist, then give them a chance to comment.]
>
> ___ **REACTIONS TO THE VIDEO**
>
> ___ **AIDS**
> 1. AIDS knowledge
> 2. Reactions to AIDS
> 3. Personal concerns about AIDS
> 4. Talking about AIDS
>
> ___ **DRUGS AND ALCOHOL USE**
>
> ___ **SEX**
> 1. General attitudes about sex
> 2. Talking about sex with friends
> 3. Talking about sex with adults
>
> ___ **RELIGIOUS VIEWS**
> 1. Being a good Christian
> 2. Religious views of sex and AIDS
>
> ___ **SHARING THE BOOKLET WITH KIDS**

- Are there any final comments you'd like to add about any of these topics?

Thanks. I really appreciate your help. Just as a reminder, I ask that you respect the confidentiality of other people's comments from today's discussion. In a moment, Kristie will give you some information about how to use the story booklets to talk to kids.

> **MODERATORS:**
> ******* *TURN OFF THE TAPE RECORDER.* *******
>
> Give Kristie the cassette tapes and tape recorder.

[TRANSITION]: Now that we've talked about some different ways that you can share the story booklet with kids, I'd like to give you some tips to get you started.]

Your envelope has several copies of the story booklet inside it. I'm going to ask you to give a copy of the booklet to **5** kids this week. Make sure you keep one copy for yourself.

We would like for you to share copies of this booklet with several teens during the next two weeks, and then we'll meet here again on Thursday, July 24 so you can discuss your experiences and talk about how we can improve the booklet.

Right now, I'd like you to think of **5** teens who you might be able to talk to about AIDS, using copies of this booklet.

THANKS for your help with this project! We really appreciate it, and we're looking forward to hearing about what you have to say about your conversations with kids.

REMINDERS FOR MODERATORS

1. Each **[TRANSITION]** is just a short introduction to the next topic.
   Just read the [TRANSITION] out loud, then immediately begin asking
   the questions in the next section.

   After asking major open questions, or before moving to a new topic or section,
   remember to summarize the topic discussion by restating one or two of the most
   important views that were said about that topic.

2. Whenever you see the cue **[SUMMARIZE],** use your judgment about
   whether to make a summary statement before moving on – if the discussion
   needs closure because various views have been expressed or because you
   need to re-focus the discussion, etc.)

To SUMMARIZE, use a reflective listening (mirroring) statement
– start it by saying something like:

> "It sounds like you are saying that…"
> "What you seem to be saying is that…"
> "What I hear you saying is that…"
> "You are worried that…"
> "Some of you seem to be saying…, while some of you seem to feel that…"

These kinds of statements can be used to help "draw" people out, to elicit more open and
honest responses from them. After you make a summary statement, give the women a
chance to elaborate on or clarify your summary before you move on to a new set of
questions.

INSTRUCTIONS

> **Give each woman envelope and handouts.**

[TRANSITION]: Now that we've talked about some different ways that you can share the story booklet with youth, I'd like to give you some handouts to get you started. I'm giving you an envelope with **5** copies of the story booklet inside it. I'd like you to give a booklet to kids in church, or in your neighborhood, or in your family. I'd like you to give a copy of the booklet to **5** youths during the next week or two. Make sure you keep a copy for yourself.

We'll meet here again at **7:30 p.m.** on **Thursday, July 24**, two weeks from now, to talk about your conversations with the kids. If possible, please bring a list of the kids that you talked to.

If you think of any questions, or if you need extra copies of the booklet, please contact Linda King or call **Kristie Swain** at **371-6981**. If you end up with extras that you don't need, please give them to one of the other women in this group so she can use them.

Thanks for your advice about this project. I really appreciate your help, and I'm looking forward to hearing about what you have to say when we talk again.

WOMEN'S FOLLOW-UP FOCUS GROUP DISCUSSION GUIDE

Moderator_____

Date_____

Place_____

Start time _____   Ending time_____

Number participants in your focus group_____

MODERATOR:

1. **Anyone who was not at the first meeting should take 2 consent forms.**
2. **Tell them to "Keep one form for yourself."**
3. **Collect the signed forms after they have signed them.**

INTRODUCTION

My name is _____, and I am _____.

I will be leading the group discussion today, and it will last about an hour.

Today we will focus on what you think about a story booklet about AIDS prevention. This booklet is a short play about kids dealing with sexual pressures in everyday situations, and it uses language that kids like to use. Some African American kids in the Highlands Presbyterian Church after-school summer program helped us make this booklet by writing skits, acting in the photos, and writing raps.

We've come here to talk with you because we heard that many of you are very involved in the community and in your churches. We're looking for African American women like you who can help teach kids about the dangers of AIDS. I'd like you to think of yourself as a helpful friend – someone who cares about whether kids in your life know about risks from AIDS and having sex. I am interested in finding out how you might talk to them about AIDS.

Your views are important to me because I'm interested to learn more about how African American women can talk to kids about AIDS. Your opinions could help save African American kids from getting AIDS.

I am not here to provide information to you or to present a point of view. I simply want to find out what you think. From my point of view, there are no right or wrong answers – just opinions, feelings, and reactions. I want to hear those from you.

Your reactions and ideas about this booklet and how it can be shared are very important to me. What you say today will be taken very seriously.

GROUND RULES

First of all, I'd like to set up a few basic ground rules for our discussion:

1. I can guarantee my confidentiality and that of the tapes, but of course I can't guarantee yours. So I'm asking you to agree to not repeat others' comments from today to anyone else. This will make it easier for all of us to talk openly.

2. I'm going to ask that only one person talk at a time, so I can hear each of your ideas and so everybody gets a chance to have a say in our discussion. Everyone will have the chance to participate. When someone is talking, I would ask that everyone else be very quiet so that each person's views can be clearly heard.

3. On some of the topics we'll talk about, it's natural for people to have different points of view and maybe even disagreements. I am interested in ALL of your ideas, whether they are the same or different from those of others. Feel free to say you disagree, if you do. But I want you to give each other the time to talk and listen to each other with respect.

> MODERATOR: Pass out small pieces of paper and pens.

Before we get started with the discussion, I'd like you to write down on a little piece of paper the number of people you have talked to about the story booklet. If you didn't talk to anybody, just write zero. It's OK if you didn't talk to anybody – we just want to count the total number of people that read and reacted to the booklet, not counting you.

> MODERATORS: Collect pieces of paper from all participants.
>
> *****BEGIN TAPE RECORDER*****

[TRANSITION]: To get started today, I'd like to talk about the kinds of conversations you've had about the story booklet with kids. If you didn't talk to anybody about the booklet, that's OK. I just want to hear from those of you that did talk about it.

SHARING THE BOOKLET

EXAMPLES OF CONVERSATIONS

- I'd like you to share your own experiences in using the booklet. [OPTIONAL: How did other people react to the booklet?]

- I'd like to hear examples of specific conversations you had about the booklet?

[SUMMARIZE].

[TRANSITION: Next, I'd like to talk about how you made decisions about how to share the booklet.]

YOUR CHOICES

- How did you pick the people you gave the booklet to?
  [PROMPT: How did you know them – from church, school, your family, your neighborhood?]

- I'd like to hear about some of the best places where you talked to them about this booklet?

  Where were the worst places to talk?

  Can you think of other places where it <u>might</u> be easier to talk about the booklet, if you did it again in the future?

- I'd like to hear some things you said when you <u>first</u> handed somebody a copy of the booklet?

[TRANSITION]: Now, I'm curious to hear about the kinds of things that happened when you handed people the booklet.

INITIAL REACTIONS

- What were some of your own feelings about talking about the booklet?

- I wonder if any kids acted embarrassed or shy when you talked with them?

- I'm curious if you saw any kids just joke around or not really say anything about it?

  [PROMPTS: Why do you suppose they acted that way? What did you do?]

- I'm interested to know if it was hard to talk about this booklet with them?

  [PROMPT: Why? I wonder if any other things made it hard or easy to talk about it?]

[SUMMARIZE].

[TRANSITION]: Next, I'd like to hear about the kinds of things you talked about, besides the booklet itself.

- I'd like to know if any of you have recently talked to any kids about AIDS or sex. [PROMPTS: What did you talk about? Was that hard to do? Why?]

- What were the best things you said?

- I'd like you to tell me the kinds of things that do not work as well?

- I'm interested to know if they ever ask you questions? If so, what do they ask you about?]

- Based on your conversations, do you think any kids feel worried about getting AIDS?

[SUMMARIZE].

[TRANSITION]: Next, I'd like to hear about how kids reacted to this booklet.

GENERAL REACTIONS

- I'd like to know what they thought was the best thing about this booklet, or what they liked the most about it?

- I'm interested to hear what they did <u>not</u> like about it?

- I wonder why some kids are more interested in the booklet than others?

- I'm curious to hear what they thought about how the booklet looks.

[TRANSITION]: Next, I'd like to talk about their reactions to the story itself.

FUTURE DISTRIBUTION OF THE BOOKLET

- I wonder if you know anybody who would like to give copies of the booklet to their friends or kids? How do you know they are interested?

- I'd like to hear any ideas about how we could distribute copies of this booklet in the community?

- Do you think this booklet could be used in church youth programs? Why or why not?

- Besides using this booklet, can you think of other ways that we could teach kids about AIDS prevention?

υ [SUMMARIZE].

INTRODUCTION TO THE STORY BOOKLET

Today, I am also asking you to be my editors, to help us fix and improve this story booklet. We will be printing copies of this booklet to give out to African American kids in Gainesville. But first, we need to find out whether you think it is interesting and helpful to read, and we want your advice about how to improve it.

[TRANSITION]: We'll get started with your overall reactions to this booklet.

GENERAL REACTIONS

- I'd like to know what you like the most about the booklet?
- I'm interested to hear what you like the least about it?
- I wonder if you think kids would react differently than you did. [PROMPT: How?]

[SUMMARIZE].

[TRANSITION]: Now, I'd like to ask you about your reactions to the characters in the story.

THE CHARACTERS

- How are the characters in the booklet like kids you know? [PROMPTS: What about Kevin? Josh? Samantha? Tatiana?]
- How are the characters different from kids you know?
- I wonder if any characters are similar to the way you were, when you were their age? [PROMPT: If so, how?] How are the characters different from you, when you were that age?

[SUMMARIZE].

[TRANSITION]: Now that we've talked about the characters, I'd like for us to talk about how the story compares with real life.

REALISM

- Some people might think this story is realistic, while others might think it's not. I'd like to hear your reactions.
- I'm curious if situations in the story have happened to anyone you know.

[SUMMARIZE].

[TRANSITION]: Next, I'd like to talk about the message of this story.

THE MESSAGE

- I'd like you to tell me the most important things you remembered from the story.

- What is the moral or overall lesson of the story?

- I wonder if the lesson of the story could be different? What kind of lesson would you use?

[SUMMARIZE].

- OK, before we move on, I want to see if there's anything else you'd like to say about your reactions to the story.

[TRANSITION]: I appreciate hearing your reactions to the story. Since you are my editors today, I want you to tell me, straight out, what you don't like about this booklet, and how you think we should fix it. I also want to hear what you <u>do</u> like and would keep.

THE BOOKLET

[TRANSITION]: First, I'm going to ask you some questions about how the booklet looks.

APPEARANCE

- I'm curious to hear how you think the booklet looks.

- What is your favorite thing about the way it looks?

- What is the worst thing about the way it looks? How would you fix it?

- What do you think about the size of it?

- What do you like best/most about the photos?

- Which pictures are your favorites? Why?

- Which pictures do you like the least? Why?

- What do you think about the lettering?

[SUMMARIZE].

[TRANSITION]: As you might remember, this booklet is supposed to be designed for African American kids. So, I'm interested to learn about your reactions, plus I want to know what kids think about the booklet.

- I'm curious if you saw anything in the story that might be confusing or hard for kids to understand.

- I wonder if you can find any words that seem out of place?
  [PROMPT: Some people might think that some words are unfamiliar or offensive.]

- What are some slang words or rhyming words that we could add to make it more interesting or real?

- What do you think about using rap in this booklet?

- If someone read this, and they didn't know a lot about AIDS, how would they probably react to it?

[SUMMARIZE].

[TRANSITION]: Next, I'd like to talk about your reactions to the story's messages about AIDS.

REACTIONS TO THE STORY

- I want to know the kinds of moods the story put you in when you read it.

- I'm interested to know if you think any part of it was funny?
  [PROMPTS: Which parts are you talking about?]

- How interesting was the story to you? Why?

- I wonder why kids will be interested in reading this?

- Some people might say this story is too serious or boring or goody-goody. What do you think?

[TRANSITION]: Next, I'd like you to think about things kids could learn from reading this. I also want to get more of your advice about what you think is good and what needs to be fixed.

THE LESSON OF THE STORY

- First, I'd like you to tell me the main things kids will probably learn from this story?

- I'm interested to know if you learned anything new about AIDS from the information on the back.

- I wonder if you can think of any other information about AIDS that should be included.

- If you could change any part of the story, what would you change?
  [PROMPTS: How would you change it? What are some other stories, characters, situations we could write about?]

- I'm interested to hear any other ideas you'd like to add about the story or the booklet.

[SUMMARIZE].

WRAP-UP

You've given me some good advice about how to make the booklet better. Now, I'm going to read through a list of the things we've talked about today, to give you one last chance to say anything else you think is important.

CHECKLIST

[MODERATOR: Read checklist aloud, giving them a chance to comment.]

____ SHARING THE STORY BOOKLET WITH KIDS
1. Examples of conversations
2. Who you picked to share it with
3. Where you talked about the booklet
4. How they reacted to the story and booklet
5. Talking to kids about AIDS and sex
6. Future distribution of the booklet

____ GENERAL REACTIONS TO THE STORY
1. What you liked/disliked about it
2. If the story is realistic
3. The lesson of the story

____ EVALUATION OF THE BOOKLET
1. How it looks
2. Hard or confusing words
3. Slang and rap
4. Mood of the story
5. Things people can learn from it
6. Other ideas

- I'd like to hear any final comments you'd like to add about any of these topics.

Just as a reminder, I ask that you respect the confidentiality of other people's comments from today's discussion. In just a moment, Kristie will give you some handouts you can use for talking to kids about AIDS.

APPENDIX B-7
PILOT STUDY QUESTIONS FOR YOUTH FOCUS GROUPS

INTRO

- What did you think about the video we just watched? How did it make you feel?

- I wonder if you know any people like Terrence? Crystal? The minister?

- I'd like you to tell me why this video was or was not realistic. Could that situation really happen, in real life? Why or why not?

SEX

- How does a person know if they are in love enough to have sex?

- I'd like you to tell me when people are old enough to start having sex?

   [PROMPTS: When you start going out with somebody? When you finish high school, college? When you get a good job? When you're ready to support a baby? When you're married?]

- What do you want to do when you group up? Why?

- In church, they say you should wait until marriage to have sex. What do you think about that advice? [PROMPT: Why do you say that?]

- Can you think of any problems people can have if they have sex before marriage? What about emotional consequences? What are some reasons a person might wait until marriage to have sex for the first time?

- I wonder if any kids in your school are already having sex.
   [PROMPT: What do you think about that?]

- Suppose your friends tried to persuade you to go after somebody. How much would they play a role in what you'd actually do? [PROMPT: Why do you say that?]

- Suppose you're going out with somebody. How do you decide how far to go with them? How long should a relationship last before you should start talking about sex?

- Suppose somebody pressured you to have sex. How would you react? Why?

DIALOGUE

- Suppose you had a problem or question about a relationship or sex. Who would you probably talk to first? Last? Why?

- How do you pick who you talk to about these kinds of things? How do you feel about talking to friends? Your mom? Your dad? An aunt / uncle? Pastor? Teacher?

- What do your parents tell you about sex? What are some things they **should** talk about?

- Suppose a friend came to you and said they just started having sex. What advice would you give your friend?

AIDS RISKS

- What do you know about AIDS, so far? How do you get it?

- Where did you first learn about AIDS? What do your friends say about AIDS?

- What do your teachers tell you about how to keep from getting AIDS? What do you think about their advice?

- How can you tell if somebody has AIDS? Do you personally know anybody who has AIDS? How did you react to them at first, when you found out?

- Suppose your best friend told you he/she had AIDS. What would you say?

- I wonder if any black teens in your school experiment with crack or marijuana or heroin?

     What do you think about them doing that?

     I wonder if anybody you know drinks or gets drunk?

     Why do kids drink or use drugs?

- I wonder if it's likely that black teens in Gainesville can get AIDS? Why or why not? How could they get AIDS?

The following table summarizes key facts about various informational handouts and other educational media used to train focus group participants to develop and disseminate the *fotonovelas*:

Appendix	Target Audience	Title of Educational Material	Number of Recipients
C-1	Youth	"How to Write an AIDS Prevention Play"	50
C-2	Women	"Tips for Using the Story Booklet"	18
C-3	Women	"How to 'Break the Ice'"	18
C-4	Women	"How to Talk to Kids about Sex"	18
C-5	Youth	"AIDS Peer Education Award"	40
C-6	Pilot Study Youth	"Excellence Award for Designing an Educational AIDS Skit"	20
C-7	Youth and Women	Transcript of "On the Pillow" video	68

APPENDIX C-1
"HOW TO WRITE AN AIDS PREVENTION PLAY"

Write a short play that shows how kids can keep from getting AIDS.
- You could show everyday situations where kids are hanging out and talking about sex and talking about how to avoid getting AIDS.
- You could show the bad things that can happen if kids do have unsafe sex.

SET THE SCENE:

1. **Who are the characters? What kind of conversation are they going to have?**
Give them names & decide how they know each other.

> EXAMPLES:
>> A couple is thinking about having sex and talks about it.
>> A friend at a party is pressuring somebody to drink and have sex.
>> Friends at the mall talk about sex and AIDS..
>> A friend secretly reveals that he/she has AIDS.
>> Mother talks to daughter about sex. / Father talks to son about sex.

2. **Where are they talking?** (A place. EX: basketball court, mall, school, on the phone)

3. **What are they doing or planning to do?** (EX: going to a party, watching TV, etc.)

4. **What happens in the story? What do the characters do? How do they resolve their problems?**

5. **What is the moral or lesson of the story?**

OTHER TIPS:
- You can have more than one scene (scene 1, scene 2, scene 3, etc.) if the place changes during the story.

- You can start with a narrator who explains the scene. The narrator can explain what's going on during the play, too.

- At the end, the narrator can explain what the MORAL OR LESSON of the story is.

- When you finish writing, write a TITLE of the play at the top.

Here's an example of how you can write the conversations in the play:

NARRATOR:	Kevin and Joshua are at school playing basketball, talking about what they're going to do later that night.
KEVIN:	My girl friend Kiesha is coming over to watch TV. (He dribbles the ball, then makes a jump shot.) You and De De can come over, too.
JOSHUA:	Well, we had a big fight last night, so I don't know. But I'll give her a call.

APPENDIX C-2
"TIPS FOR USING THE STORY BOOKLET"

Each time you give a booklet to a child:

1. Ask them to read the booklet.

2. After they've finished reading it, ask them for their reactions to it. Some examples of questions are listed below.

3. Listen carefully, and remember what they say. There is a form in the back of your envelope where you can write down the names of the kids you talk to. It would also help to take notes about what they tell you, so it will be easier for you to talk about it when we meet next time.

4. Ask them to sign your list (inside the envelope).

Some questions you could ask:

1. I'd like to know what you thought was the best thing, or what you liked most about this booklet?

2. I'm interested to hear what you thought was the worst thing, what you liked the least about it?

3. How are the people in the booklet like people you know? What about Kevin? Josh? Samantha? Tatiana? How are they different from people you know?

4. I wonder if any of the people in the story are similar to you? How are they different from you?

5. What do you think about how Samantha and Kevin treated each other? What about the way Josh treated Tatiana?

6. In the story, who do you think was acting cool? Who was not cool? Why?

7. I wonder why Samantha was so worried about getting AIDS?

8. Some kids might think this story is realistic, while others might think it's not. I'd like to hear your reactions.

9. I'm curious if any situations in the story have actually happened to kids you know.

10. I'd like you to tell me the most important things you learned from the story.

11. What is the moral or lesson of the story?

12. I'm curious to hear how you think the booklet looks.

13. Which pictures are your favorites? Which do you like the least? Why?

14. I want to know the kinds of moods the story put you in when you read it.

15. I'm interested to know if you think any parts of the story are funny? Scary?

16. How interesting was the story to you? Why?

17. I'm interested to know if you learned anything new about AIDS from the information on the back.

18. I wonder if you can think of more information about AIDS that should be included.

INSTRUCTIONS FOR FOLLOW-UP:

We'll meet here again at 7:30 p.m. on Thursday, July 24 to talk about your conversations with the kids. I'd like you to bring a list of who you talked to, so we can talk about those conversations. I'd like you to share booklets with kids wherever you usually talk to them -- in church, in your neighborhood, in your family, on the streets.

If you think of any questions, or if you need extra copies of the "Afternoon Delight" booklet, please call **Kristie Swain** at **371-6981**. If you end up with extras that you don't need, please give them to another women in this group so she can use them, or bring the extras back when we meet here again. I just ask that you don't throw any booklets away.

Don't just hand out copies of the story booklet.
- Make sure you engage each child or teen in a conversation about the booklet, so they'll know why you are giving it to them.
- The goal of the booklet is to help you open up a conversation about AIDS or sex.
- Talking about the booklet may let them know they can come to you for advice and help.

For each child, choose the right time and place to give them a booklet.
- You'll need privacy – a place where you can talk one-on-one – so they're not distracted or embarrassed by having their friends or brothers or sisters around.
- Talk to kids when you're not in a hurry – when you don't seem distracted and rushed.
- Relax. Effective communication can't happen if everyone is tired or tense.
- Set aside enough time to really connect.

Be confidential.
- Assure them that you won't tell anybody else about the conversation.
- Don't share your conversations with anyone else unless you get their permission.

Use the story booklet to create a "teachable moment."
A teachable moment occurs when your child can learn something from an everyday occurrence, like the pregnancy of a friend, or topics discussed in school, on TV, in song lyrics, or in the movies. The booklet *"Afternoon Delight"* can be used to create an opportunity to share your values and start a conversation about personal issues like sexuality. For example, you can ask your child what they think about a scene in the story, and then offer your feelings as well. This could be a great springboard to a lengthy conversation about personal issues like sex that you might otherwise have a hard time starting.

Ask lots of questions about the booklet to show that you're interested in what they think.
You can ask some questions listed on the *"Tips for Using the Story Booklet"* handout.

Really listen.
- Effective listening is more than just "not talking."
- Make eye contact.
- Acknowledge what they're saying.
- Show that you understand, even if you don't agree.
- If you don't understand, ask kids to clarify what they are really trying to say.

Encourage kids to ask questions.
- Then listen and try to answer their questions to the best of your ability.
- Consider what kids are able to understand at different ages.
- Admit that you don't have all the answers but will try to find out.
- Be willing to keep talking until kids are satisfied with the information.
- The more conversations you have about sexuality issues, the more comfortable and confident you both will become.

Once you're ready to talk about their own life, start with a comfortable subject.
Once you've broken the ice, you can gradually move toward more difficult or embarrassing topics. For example, if you're worried that one of your child's friends is a bad influence, start by talking about what his or her friends are up to in general and then move on to the more difficult subject.

Avoid being "preachy."
- Don't lecture. Avoid saying things like "You should not…"
- You shouldn't do all the talking. Let your child have equal time.
- Use a friendly tone of voice, so they won't think they've done something wrong or that you are suspicious of them.
- If you're only trying to get your point across, you'll never hear their side of things.

Share an experience you had at their age.
For example, you might say, "When I was in fifth grade there was a boy in my class who said he already had sex. Nobody believed him though."

Say things to boost their self-esteem.
Each time you talk, praise at least one positive thing in his or her life or behavior.

APPENDIX C-4
"HOW TO TALK TO KIDS ABOUT SEX"

The direct approach is usually the best approach.
For example, if you think your 11-year old daughter is going out with boys without your permission, in a calm, direct voice say, "I have a problem with girls your age going out with boys, and I'd like to talk about it." If the child becomes too emotional, don't overreact. At least it's out in the open and you can come back to it later.

State how you feel.
When adults talk about their feelings, it puts kids more at ease. That's because most kids are used to lectures and being told what to do. For example, if your grandson uses dirty language to describe a girl in school, you could say, "It really disappoints me to hear you talk about another person like that. Do you know what I mean?"

Tell them you're there for them if they ever have any questions about anything.
- Be easily approached for information and guidance.
- Keep the lines of communications open all the time.
- Frequently ask them what they're thinking about.
- You can help them the most if you try to understand what is really going on in their lives.
- If you can't talk with your child, it will be hard to influence his or her behavior.
- Don't assume that they feel comfortable coming to you about personal issues.
- Don't turn them away, even if you feel uncomfortable with the topic they want to discuss.

Remember, all kids are different.
- Even though you might think kids in elementary school may be too young to be even interested in sex, it's important to talk with them before the age of 12.
- Kids over 12 are much more heavily influenced by their friends and the media than by their parents or other adults.
- There are basic patterns for kids' development, but the only way to be completely sure what they are thinking is to talk to them directly.

Start communicating early.
- Most parents think sex education starts when their kids are physically mature and already have started dating.
- Ideas about healthy, respectful relationships will stick with your kids better if you start talking early on about friendships and other kinds of relationships.
- Even pre-schoolers can understand these ideas if you explain it in their language.

Tell them that you want them to abstain from sex.
- Believe it or not, most people just don't bother to tell kids that they don't want them to become sexually active.
- Kids <u>are</u> influenced by the opinions of adults they respect.

Share your reasons for not wanting them to have sex.
- Tell them why you think it's a good idea if they abstain from sex until they're older.
- Discuss the consequences of sexual activity and pregnancy.
- Talk about the dangers of AIDS and other sexually transmitted diseases.

Acknowledge peer pressure.
- Don't make light of peer pressure to have sex or brush it off by just saying, "Ignore it."
- Remember that kids are being pressured to become sexually active at a younger and younger age.
- The influence of peers is important in kids' lives and affects their self-esteem.
- Most young teens are afraid that if they say "no" they won't be popular.
- By getting to know their friends, you can use peer pressure in positive ways.

AIDS Peer Education Award

Presented to

_____

For excellent work in teaching friends about AIDS awareness

Presented by

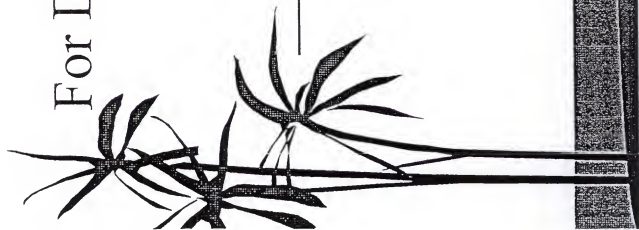**The African American AIDS Task Force**

Thursday, July 10, 1997

Kristie Alley Swain,
AIDS Awareness Coordinator

Co-Pastor Linda King,
Showers of Blessing Harvest Church

Excellence Award

For Designing an Educational
AIDS Skit

Awarded To

June 17, 1997
Westcoast Fellowship
Vacation Bible School

A 9-minute film written, directed, produced, and photographed
By Parrish Smith (1995)
A Swee Pee Film: Sebastian Productions
Washington, DC: Divinity School, Howard University

[Opens with sounds of cars driving down a road and a car parking. A young African American man sits in the car. He finally gets out and walks over to a riverside city park, where an older man in a trench coat is waiting for him. The young man, Terrence, walks over to greet the older man, who is his minister.]

REV. BARNES:	Ahh. Here he is. I wasn't sure if you was still coming.
TERRENCE:	I'm really sorry for being late, Reverend Barnes, but uh, I had a delay.
REV. BARNES:	Hey, don't worry about it. Come on. Let's sit over here. So Terrence, is it cold enough for you?
TERRENCE:	*(Shivers.)* It's too cold out here. Feels like it's 30 below.
REV. BARNES:	*(Laughs.)* Man, you're just warm blooded. You see, you have to be cold blooded to be able to enjoy this weather.
TERRENCE:	So I take it you enjoy it?
REV. BARNES:	Enjoy it? Son, let me tell you something. I could sit out here in my shorts and a T-shirt, while eating ice cubes, and I'd still sweat. *(Laughs.)* Terrence, every day that God makes is a gift. So how's your job going?
TERRENCE:	It's going good.
REV. BARNES:	How's Alicia doing? Don't tell me you're worried about the marriage. You know, she's gonna make you a beautiful wife.
TERRENCE:	Alicia, she's doing well.
REV. BARNES:	All right. OK, so you made an 8 o'clock a.m. appointment with me, just to shoot the breeze? Terrence, look at me. What is the problem? Don't talk to me as your pastor. Talk to me as your friend.
TERRENCE:	Reverend Barnes, I don't know what to do. I don't even know how it happened.

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REV. BARNES: How what happened?

TERRENCE: See, last month, in March, me and a couple of friends went out to
                 Joplin's about 9 o'clock. We must have drank two pitchers in two
                 hours' time. So you see, then it was 11 o'clock.

[Scene shifts to bar.]

TERRENCE: I was sitting at the bar, waiting for the bar tender to refill my
                 pitcher. And a very attractive lady walked in and started looking
                 around. I mean, heads were just turning left and right. That's how
                 beautiful she was. I'd never seen her before. And I don't think
                 anyone in there had ever seen her before. But she walked over and
                 sat next to me and even struck up a conversation.

[Scene switches back to park.]

REV. BARNES: I still don't see what the problem is.

TERRENCE: *[Sighs.]* She said her name was Crystal. She said she worked for
                 Osterall Corporation, some engineering corporation out in
                 Bethesda. Anyway, she said she was 26. *[Sighs.]* The fact of the
                 matter is I was a little drunk. But I was still sober enough to know
                 that she was making passes at me.

[Scene switches to bar.]

CRYSTAL: Let's go back to your place.

[Scene switches to park.]

TERRENCE: And I accepted. Why?

REV. BARNES: Why? Because Alicia cheated on you?

TERRENCE: Because I wanted to. I wanted to get it all out of my system then,
                 not after I walk down the aisle. So anyway, we went to my place,
                 and we wasted no time.

[Scene is Terrence's apartment.]

TERRENCE: From the second we walked in the door, Crystal was all over me.
                 Now that I think about it, she was in total control throughout the
                 entire night. *(Laughs.)* It's funny, because before I met Alicia, I
                 was always the aggressor. It's almost scary. She had this
                 controlling, dominating, focused, eerie look in her eye which made
                 me submit to everything and anything she wanted to do.

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[Scene switches back to park.]

TERRENCE: It was the best sex I ever had.

[Scene is Terrence lying in his bed.]

TERRENCE: But when I woke up the next morning, not only was Crystal gone, but lying there on the pillow was a note from her.

[Scene switches to park.]

REV. BARNES: What did it say?

TERRENCE: *(No response.)*

REV. BARNES: Terrence, what did the note say?

[Scene switches back to Terrence's bedroom. Terrence opens note on the pillow, sits on the edge of the bed and reads it silently, then throws it down on the bed. The note says, 'Welcome to the World of AIDS.']

[Scene switches to park. Terrence hands the note to Rev. Barnes.]

REV. BARNES: Terrence, please tell me you used a condom.

TERRENCE: I did. I had one. But I don't know what –

REV. BARNES: You don't know what happened to it?

TERRENCE: At first, I thought it was all a hoax. Then I got checked.

REV. BARNES: You're positive.

TERRENCE: *(Nods.)*

REV. BARNES: Alicia doesn't know.

TERRENCE: No. Reverend Barnes, she's pregnant.

REV. BARNES: Alicia's pregnant?

TERRENCE: She's two weeks pregnant.

[Terrence sobs. Rev. Barnes embraces Terrence to comfort him.]

REV. BARNES: *(Shouts)* What the hell is wrong with this world?

APPENDIX D
"AFTERNOON DELIGHT" *FOTONOVELA*

The following appendix displays the *fotonovela*, titled "Afternoon Delight." The story script was created by youth participants, and the booklet contains photographs of many of these teens. The *fotonovela* was disseminated to at least 300 teens in the black community by the youth and women who participated in the focus groups.

Appendix	*Fotonovela Development*	Dissemination of *Fotonovelas*	Total Recipients
D-1	Youth focus group participants wrote AIDS prevention skits and raps, performed these for peers, and did role-playing for the photographs.	Youth focus group participants were given 50 *fotonovelas* to share with friends. Women in the focus groups received 150 *fotonovelas* to share with their own children, as well as with the children of neighbors and friends. Other church members, as well as a manager of a low-income housing complex, received 100 *fotonovelas*.	300

AFTERNOON DELIGHT

A story about kids like us

Carla, a girl with HIV, comes to church Sunday as a guest speaker, to talk about AIDS.

CARLA: So, my boyfriend Jamal didn't know he was infected with HIV. We only had sex one time, but it changed my life forever.

Her church, everybody gathers outside for a barbecue picnic.

TATIANA: I can't believe a girl our age could really, like, get AIDS from her boyfriend.

SAMANTHA: Yeah, and they only did it once. It makes me worried. My boyfriend Kevin keeps sayin' that if I loved him, I'd prove it by having sex with him.

KIESHA: What you worried about? You're goin' with the best basketball player in school. Most girls would do anything for the chance to go with a guy like that!

SAMANTHA: Hey. Watch it, girlfriend! Look, he's checkin' me out now.

Kevin sits with Samantha. His friends, B.J. and Josh, shoot some baskets.

B.J.: Hey, Josh. Out of all of us, who do you think has the best chance of going pro?

JOSH: No contest. Kevin. I mean, he's the best.

B.J.: But his mind ain't on the game. All he thinks about is how to get Samantha into bed. He can't play that way.

JOSH: I hope he don't get AIDS or get her pregnant.

FROM A LEMON TO A LIME

From a lemon to a lime,
And a lime to a lemon

I did more sins
Than the AIDS did killin'

But AIDS won't take me,
'Cause I know how to respect it.

I'm fightin' for my dream,
Yeah, I'm ready to protect it.

B.J.: That would really mess things up. He could kiss his dreams to go pro goodbye.

JOSH: Yeah. Sex can really mess up your game.

The next morning at school

KEVIN: Hey, Josh. My mom won't be comin' home from work today 'till 7 or 8. Maybe you and Tatiana could come over. I'll invite Samantha. We could rent a movie.

JOSH: Sure. That'd be cool. I'll ask Tatiana during lunch.

KEVIN: Meet you here, after 6th period.

After school, they walk to the store

JOSH: Got the Cokes and popcorn. You get the movie?

KEVIN: Yeah. Check it out - "Mo Booty." A porno flick will put our ladies in the mood, no doubt! Plus, I got condoms. Maybe we'll get lucky.

JOSH: Man, that movie ain't so cool. Tatiana's gonna be embarrassed. But if you gonna have sex, you best use those rubbers, sure 'nuff.

It Kevin's house, they all watch the porno movie. When it's over, Tatiana offers to walk the dog and Josh goes with her.

KEVIN: Well, Samantha. We're finally alone. You're so sweet. And so pretty. I'm gonna make you feel so good.

SAMANTHA: We ain't gonna do nothin'. You know I've never done anything like this before. And I'm scared. I'm not ready to be a mother, or even worse - to die of AIDS.

KEVIN: It won't happen to you. Listen. I'm tired of this. If you love me, you'll do it.

SAMANTHA: No. If you love me, you'll lay off. Besides, how can I love someone who doesn't respect my feelings?

KEVIN: Fine. I'll find somebody else.

SAMANTHA: Oh, yeah? Like who?

Outside on the sidewalk

JOSH: I'm sorry about that move. It wasn't my idea.

TATIANA: Think you're slick, tryin' to use a porno to get me into bed.

JOSH: Look. Kevin may be thinkin' that way, but I'm not. I love you, Tatiana.

TATIANA: I love you too, Josh. It makes me so happy to have a mature boyfriend who really respects me.

JOSH: I hope we'll get married some day. Then we'll be ready to have babies and we won't have to worry all the time about getting AIDS. I want us to have a great future together.

TATIANA: It seems like such a long time to wait. It's gonna be worth it, though. 'Cause nothin' has to get in the way of our dreams.

"What you learn from this story could save your life. I hope you'll share it with your friends. My advice is this: Take charge of your own life. Respect yourself, protect yourself!"

LEARN THE FACTS ABOUT AIDS

▶ You can't get the AIDS virus from toilet seats, water fountains, or shaking hands.
▶ Sharing needles for drugs or body piercing can give you HIV, the virus that causes AIDS.
▶ Another way to get HIV is through sex.
▶ A person can have HIV for 10 years or longer without knowing it.
▶ Latex condoms can help protect you.
▶ Not having sex is your safest choice.

WORD UP!

▶ Every hour, one African American child or teen dies of AIDS.
▶ More than 7 times as many black kids as white kids have AIDS.
▶ In the Gainesville area, the number of African American women with AIDS has tripled in the last few years.
▶ AIDS causes 1 in 3 deaths among black men, 1 in 5 deaths among black women.

CALL THE FLORIDA AIDS HOTLINE: **1-800-FLA-AIDS**
OR THE NATIONAL AIDS HOTLINE: **1-800-342-AIDS**

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RAPS FOR SMART KIDS...

THE BOTTOM LINE

They say sex is wrong.
Sex is not right.

But if you go out and do it,
You could get AIDS that night.

And that's the bottom line,
So watch what boy or girl you call fine.

Because some of them will put you in a bind.
And that's the bottom line.

APPENDIX E
CODE LIST

Predisposing Factors
Religiosity
Church is our main background
Conscience about premarital sex
The "life before"
"Out there" in the world
The "slip up" (just one mistake)
Backsliding, "tip-toeing around"
Religiosity and sexual attitudes
God's word and rules
The Christian lifestyle
"Babes in Christ"
Fearing God
Expressions of religious feeling
Bible teachings on sex
Sin, confession of sin
Lack of guilt or remorse, no conscience
The problem of "transferring religion to your kids"
Why people go to church (motives)
Christians should be examples to others
"Before Christ / After salvation"
Inner spirit as guide
Institutional vs. personal Christianity
"Appearances are deceiving"
What does a PLWA look like?
AIDS awareness
Prior experience w/AIDS as a health care provider
Questions about well-known things
Gender differences in teen attitudes about sex/AIDS
Healthy living
How is AIDS really spread?
Drinking and drug use
Partying (risky situations)
Drug use / trafficking on streets
Prostitution / double risk (sex, drugs)
Risky personal behaviors
Homosexual behaviors
Chain reaction (AIDS transmission)
Truancy / skipping school a lot
Hard to find a good man
Senior citizens aren't promiscuous
Casual sex
Teen sex / pregnancy

"Their little gonads are screaming"
"First feel" of a man
Bathroom sex
Safer sex negotiation
Condom attitudes
The search for a good man
How long should you know him first?
Falling in love
Marriage is a risk
Infidelity
Detecting when he cheats
"All men are bad"
Women deliberately infect men with AIDS/ get revenge
How youngest kids deal with sex
Why do kids have sex?
Effects of SES on whether teens are sexually active

Environmental Factors
Local AIDS situation
Stigma of health department for AIDS testing
Neighborhood environment
Life in the projects, on the streets
The "red light" district
Where people "hang out"
Where to get "a piece of the action"
Poor white side of RR tracks= prostitution; poor black side = drug dealers
Blacks get drug money at plasma donation center
Police don't help unless it's an election year
Police won't "take a bite out of crime" in the "projects"
Kids at risk in juvenile detention, Job Corps
Extended family
Family support depends on church leadership
Surrogate moms
Working moms – problems and opportunities
Teens' family background
Past conversations with parents about sex
Church as center of heritage and community
Oral tradition
Shouting, we're louder in church
"Spreading the word"

728

Kids are corrupted by TV & media images
of sex
"Garbage on TV" / religious censorship of
TV content
Christian community's response to
anti-religious initiatives

Message Design and Delivery
Diffusion / dissemination of *fotonovelas*
Best / worst places to distribute *fotonovelas*
Favorite parts of the *fotonovela*
Existing AIDS campaign: TV/radio PSAs, hand
out brochures at festivals, quilt project
Meanings of different words: like "bad"
is "good"
Who are the heroes for teen boys, girls?

Cognitive Processes
Interest, attention to existing AIDS materials
Sexual scripts
"Putting up a fight" / resistance to
sexual pressure
Girls' perceptions of boys' behavior
Situations where girls lose their virginity
Sexual psychology, immaturity of teen boys
Perceived threat
Perceived severity
"The one time"
Teens' perceptions of AIDS attitudes
Teens' attitudes about AIDS threats
Teens' perceptions of what it takes to
persuade people to change their behavior
Girls' perceptions of boys' motives

Normative Processes
Why people "give in" sometimes
Teens' perceptions of peer pressure
Women's perceptions of teen peer pressure
Peer effects on kids' opinions about AIDS
Teens' perceptions of teen sex
Sex talk among friends
Teens' perceptions of friends' sexual behavior
Teens' perceptions of how kids respond to
abstinence advice
How parents can help teens deal with
peer pressure
[Prescriptions vs. prohibitions:
the church vs. "out there"]
How common is adultery in the ministry?
"Bad people" / those who make mistakes

Why does only one church in 10 get involved?
If one church gets involved, the "word travels"
Interest rises when need arises
"Word of mouth travels fast"
Talking with kids about sex
"When I was growing up…"
"The talk"
Do kids really listen to parents?
Teens: "If I was a parent…"
How teens plan to raise their own children
Kid's views of talking with adults about sex
Parents' motives from kids' POV
"Play friends"
Kids' perceptions of denial among parents
How parents' sex talk with kids is different
between whites & blacks
Women's perceptions of kids' reactions to
video
Women's perceptions of how kids respond
to AIDS education
AIDS attitudes of "old people"
What's "cool"?
Perceived racial differences in AIDS
prevention

Enabling Factors
"Telling our stories"
AIDS testing (in real life)
Willingness to get AIDS test before having sex
Spiritual conscience/guide = the Holy Ghost
Church AIDS education can work
"Make it real"
Open lines of communication
Take charge of yourself
Get involved in counseling
Personal contact with PLWAs and/or
knowledge of their experiences
Social support
Christian compassion
Evangelism / "plant seeds" / outreach
Inner spirit's advice
Why I want to be in AIDS ministry
Why support groups work in the "big cities'
Help PLWAs because they're black
Unity among black churches empowers
the community
"Bring educational foods to the table"
AIDS organizations can help churches
Goal-setting, brainstorming, launching
Inroads, outreach
"Keep it going", momentum

Make it visible, go ahead and do something
Fairs, festivals, breakfasts, coming together
Take advantage of captive audiences
Find folks with expertise and connections
Multicultural networking helps
Grassroots efforts are best
Providing meals, hugs for PLWAs is a
  top priority
Grandmothers are an untapped resource

Barriers
Genocide theories about AIDS
"Africans didn't have affairs with
  green monkeys"
AIDS = "Gay disease"
AIDS = plague, punishment, doom, prophesy
AIDS = curse from God, retribution
AIDS = "the long illness"
Misinformation/myths about AIDS/HIV
Lack of knowledge about AIDS
You can "just tell" if somebody's HIV+
They think AIDS is airborne
"It won't happen to me" / "I'm different"
Distance / it's far away/ not us
"Sitting back"
Denial
Teens' perception that parents are in denial
Insufficient effort
I don't want to learn more about AIDS
Low perceived efficacy of AIDS talk
Just use common sense
Condoms don't totally protect anybody
Condoms OK for other kids, not our "angels"
"Litmus test": give out condoms on streets,
  not in church
Scare tactics don't work
Movie-type drama could reduce realism
Church or salvation keeps you safe
Secret sins
Sneaking / "sneakiness"
Resistance among clergy (to dealing
  with AIDS)
How ministers spend their time, their priorities
Churches unprepared for surge in PWLAs
Divine healing of AIDS/burden on the
  individual
Church AIDS outreach is limited or
  non-existent
Deceptive men in the church
"Covering it up" / Hiding mistakes
Preachers won't talk about AIDS

Preaching to the converted about drug use
Homosexuals should be forgiven but must
  reform or be "unsexual"
Religious apostasy / stop attending church
Ignorance/apathy about religious beliefs and
  heritage
Grandmamas don't make kids go to church
  anymore
Stigma
"Those kinds of people" vs. "innocent victims"
Judgment of others / responses to PLWAs
Fear of AIDS, contagion
They won't sit in the same pew with a PLWA
They're afraid a PLWA will ruin their dishes
Stigma surrounding an AIDS service
PLWA's social difficulties and challenges
Acute needs: medications, financial burden,
  "red tape," delays
Dying alone, trauma for PLWA's children
Others' stigma "hurts my feelings" too
Excuses to avoid contact with PLWAs
Don't help PLWAs even if they're black
"Getting past the people who hold the past up"
Teens' negative views of Af. Am. PLWAs
Gossip, lack of confidentiality
Going public with AIDS status
Hypothetical rejection or fear of friend
  with AIDS
Burdens imposed by PLWAs on others
Perceptions of others' misconceptions
Lack of access to health care for black PLWAs
Horror stories: sexual abuse & incest
Deep hurts
Girls feel unloved and need self-esteem
Rebelliousness among teens (against parents)
Generation gap is problem
Moms act shocked at kids' behavior
We have to stop kids, "set their brains"
Barriers to talking with kids
Parenting failures (stories): what can you do?
Existing parenting programs have weaknesses
Lack of action by adults (to help kids)

Outcomes
Teens parrot what they've been taught
Naïve vs. savvy reactions to AIDS issues
Girls say they want to remain abstinent
Unexpected responses to booklet
Kids talk with minister about sex and intentions
Teens talk with friends about AIDS and booklet
Long-term dialogue about AIDS and booklet

APPENDIX F
INFORMED CONSENT FORMS

The following table summarizes key facts about the informed consent forms used with all research participants in the study.

Appendix	Participants	Informed Consent Form	Number of Recipients
F-1	All adult participants in long interviews	In-Depth Interview Consent Form	10
F-2	Women	Focus Group Consent Form	18
F-3	Youth focus group participants & *fotonovela* evaluators	Parent Consent Form	69
F-4	Youth focus group participants and *fotonovela* evaluators	Youth Assent Script	69
F-5	All participants	Institutional Review Board letter of approval	
Total Recipients			97

INFORMED CONSENT FOR IN-DEPTH INTERVIEW

My name is Kristie Swain, investigator on a dissertation research project, "Barriers and Inroads to HIV Prevention In The African-American Church: A Community Study." I may be reached at 371-6981 or 392-5410 in the College of Journalism & Communications at the University of Florida should you have any questions.

Thank you for your willingness to participate in this research project. You will be asked to participate in one in-depth interview session that should last about an hour. Before we start the interview, I would like to reassure you that as a participant in this project you have several very definite rights.

- First, your participation in this interview is entirely voluntary.
- You are free to refuse to answer any question at any time.
- You are free to withdraw from the interview at any time.

This interview will be audiotaped. Tapes will be kept under lock and key in the College and will be available only to me. The tapes will be transcribed and then destroyed.

Excerpts of this interview may be made part of the final research report, but the interview and transcripts will be kept strictly confidential. Written transcripts will be available only to members of my dissertation committee.

Please sign this form to show that you have read and understood its contents:

I have read and I understand the procedure decribed above.
I agree to participate in the interview.
I have received a copy of this description.

_____   _____
        Signature and date   Signature and date
          (Participant)   (Investigator)

Would you like to receive the results of this research project? (Check one)
____ YES   ____ NO

If you checked "YES," please write an address where the report may be sent:
_____
_____
_____

FOCUS GROUP PARTICIPANT CONSENT FORM

My name is Kristie Swain. I am a graduate student at the University of Florida in the College of Journalism & Communications. I am interested in the barriers and inroads to AIDS prevention in the African American church and how women can use a story booklet to share AIDS prevention information with youth. As part of my doctoral research, I need to gather information about these issues.

Thank you for your willingness to participate in this research project. You will be asked to participate in two informal focus group sessions that should each last about an hour and a half. We will have one session today and another one two weeks from today.

There is no anticipated risk to you. You may benefit from this project by learning more about AIDS and about specific things you can do to help slow the spread of AIDS in our community.

Before we start the focus group, I would like to reassure you that as a participant in this project you have several very definite rights:
- First, your participation in this focus group is entirely voluntary.
- You are free to refuse to answer any question at any time.
- You are free to withdraw from the group at any time.

This session will be audio taped. The cassette tapes will be kept under lock and key and will be available only to me. The tapes will be transcribed and then destroyed.

Your name will not be included in this report. Excerpts of the focus group conversations may be reported in my dissertation, but the transcripts will be kept strictly confidential to the extent provided by law. Names will not appear on transcripts. Only myself and my two dissertation supervisors will have access to these transcripts.

If you have any questions, please call me at 371-6981. My university address is 2000 Weimer, P.O. Box 118400, Gainesville, FL 32611. If you would like to talk to my supervisor, Dr. Deborah Treise, you can call her at: 392-9755. Questions about participants' rights can be directed to the UFIRB Office, P.O. Box 112250, University of Florida, Gainesville, FL 32611-2250.

You will be provided with a copy of this form to keep.
Please sign this form to show that you have read it:

> *I have read the procedure described above.*
> *I agree to participate in the focus group interview.*
> *I have received a copy of this description.*

_____   _____
FOCUS GROUP PARTICIPANT   INVESTIGATOR

                    _____
                    DATE

My name is Kristie Swain. I am a graduate student at the University of Florida in the College of Journalism & Communications. I am interested in the barriers and inroads to HIV discourse in the African American church and how people can use a *fotonovela* brochure to share abstinence-based AIDS prevention information with their family and friends. As part of my doctoral research, I need to gather information about these issues.

There is no anticipated risk to your child. Your child may benefit from this project by learning more about AIDS and about specific things he or she can do to help slow the spread of this disease in our community.

Your child will be asked to participate in an informal focus group session that should not last more than one hour. I will ask members of their youth group to develop a short skit about why it's important to wait until marriage to have sex, to avoid getting AIDS. I will ask them questions about what they think of this issue, to help guide them in developing the script for the skit.

After revising this script, the youth will meet again to act out the script, and I will take a photo of each scene. These photos will be paired with the script to assemble a *fotonovela*, which is a booklet depicting the skit. The photos that are not used will be destroyed. Copies of the *fotonovela* will be distributed to the youth group as well as to two women's Bible study groups, along with instructions for how to use them as a discussion tool for outreach to others they know.

I will ask your child's permission to participate in this skit writing focus group, as well as permission to be photographed. Your child does not have to answer any question he or she does not want to answer. Your child may participate in the focus group without being photographed. Although I can offer no monetary compensation or prizes for your child's participation in this study, a pizza party will be provided.

I will audio tape the focus group session. The cassette tapes will be kept under lock and key and will be available only to me. The tapes will be transcribed and then destroyed.

Although photographs of your child's dramatization in the skit itself may be used in the *fotonovela* brochure, your child's name will not be included in the focus group transcripts, the *fotonovela* nor in my dissertation. Excerpts of the focus group conversations may reported in my dissertation, but the transcripts will be kept strictly confidential to the extent provided by law. Only my two dissertation supervisors and I will have access to these transcripts.

YOU ARE FREE TO WITHDRAW PERMISSION FOR YOUR CHILD TO PARTICIPATE IN THE STUDY OR TO WITHDRAW PERMISSION FOR ME TO USE YOUR CHILD'S DATA OR PHOTOGRAPHS OF YOUR CHILD WITHOUT ANY PENALTY OR PREJUDICE.

Please discuss with your child the fact that a student from UF will be coming to his or her youth group, and that it is okay to participate in the focus group and to have photographs taken of his or her participation in a skit.

If you have any questions, please call me at 371-6981. My university address is 2000 Weimer, P.O. Box 118400, Gainesville, FL 32611. If you would like to talk to my supervisor, Dr. Treise, you can call her at: 392-9755. Questions about participants' rights can be directed to the UFIRB Office, P. O. Box 112250, University of Florida, Gainesville, FL 32611-2250.

You will be provided with a copy of this form to keep. Please sign this form to show that you have read it:

I have read the procedure described above.
_I voluntarily agree to allow my child, _____,_
to participate in Ms. Swain's AIDS prevention study.
I have received a copy of this description.

SIGNATURES:

_____   _____
Parent / Guardian   Date

_____   _____
Parent / Guardian   Date

My name is Kristie Swain. I am a student at the University of Florida.

I want to find out what youth think about AIDS and waiting until marriage to have sex. I also want to find out what kinds of skits youth can make up about preventing AIDS.

Has your parent or guardian told you I might talk with you in this group?

If it's OK with you, I will ask you and your friends a few questions. Then, I'll help you all make a skit about preventing AIDS. If you agree to be in the skit too, I may take pictures of you acting out the skit with your friends. Then I will make a booklet. It will show pictures of the skit. I will give the booklet to other people in Gainesville.

I cannot give you money or prizes for talking with me. I won't tell your teacher or family or friends anything you say today in this group. You do not have to answer any question you do not want to answer. You can withdraw from the group any time. If you don't want me to take pictures of you, I won't take them.

If you have any questions, please ask me.

UNIVERSITY OF
FLORIDA

Institutional Review Board

98A Psychology Bldg.
PO Box 112250
Gainesville, FL 32611-2250
(352) 392-0433
Fax (352) 392-0433

June 12, 1997

TO: Ms. Kristie Alley Swain
          2000 WEIM

FROM: C. Michael Levy, Chair,
          University of Florida Institutional
          Review Board

SUBJECT: Approval of Project #97.381
          Barriers and inroads to HIV discourse in the African American church:
          development of a fotonovela for network diffusion of abstinence...
          Funding: Unfunded

I am pleased to advise you that the University of Florida Institutional Review
Board has recommended the approval of this project. The Board concluded that
participants will not be placed at more than minimal risk in this research.
Given your protocol, it is essential that you obtain signed documentation of
consent from each participant over 18 years of age, and from the parent or legal
guardian of each participant under 18 years of age. When it is feasible, you
should obtain signatures from both parents. Enclosed are the dated, IRB-approved
informed consents to be used when recruiting participants for this research.

If you wish to make any changes in this protocol, you must disclose your
plans before you implement them so that the Board can assess their impact
on your project. In addition, you must report to the Board any unexpected
complications arising from the project which affect your participants.

If you have not completed this project by June 9, 1998, please telephone
our office (392-0433) and we will tell you how to obtain a renewal.

It is important that you keep your Department Chair informed about the status
of this research.

CML/h2

cc: Vice President for Research
    Drs. Treise & Walsh-Childers

BIOGRAPHICAL SKETCH

As a fifth-grader, Kristie Alley Swain wrote in her diary of her dreams of finding a cure for cancer. She wanted to grow up to be a medical researcher to save people from disease. Dr. Earl Alley, her father and chemistry professor at Mississippi State University, encouraged her love of medical research and helped her develop the scientific research skills she would need to follow her dreams.

While a high school student in Starkville, Mississippi, she completed university pre-med courses in calculus and chemistry at MSU. Her independent research projects included studies of pharmacology, pesticides, fluid dynamics, botany, psychology, and physics. She invented a technique for analyzing pesticide binding to proteins, and her fluid dynamics experiments of the 'rope-coil effect' of viscous liquids won her a U.S. Army Corps of Engineers Research Award.

As a pre-med student at the University of Mississippi, Kristie continued her preparation for medical school and returned to her journal writing – poetry, philosophy, observations, quotes from professors and peers, and spiritual insights. Her Jesuit philosophy professor, orchestra professor, and violin instructor all encouraged her to pursue her intense interest in writing. She took a summer position writing home remodeling articles for *Better Homes and Gardens* magazine in Des Moines, Iowa. In 1988, Kristie earned her bachelor's degree in journalism with a magazine emphasis and took a full-time position writing general assignment stories and features for the *Northeast*

Mississippi Daily Journal in Tupelo. Her stories won investigative reporting awards from the Mississippi Press Association as well as from her newspapers.

In 1990, she took a senior writer position at the *Tuscaloosa (Ala.) News* and worked as a summer travel writer for *Southern Living* magazine. In 1992, Kristie earned a master's degree in journalism at the University of Alabama with a research emphasis in journalism ethics and national agenda building of religious right issues.

In fall 1992, Kristie went on to the University of Florida to pursue her Ph.D. in mass communication. There, she continued her teaching in news reporting and returned to her first love – medical research. She began studying the prevention of another deadly disease – AIDS, but this time through examining human behavior rather microscopic pathogens. She developed such research interests as coverage of minorities in health stories, Chinese AIDS beliefs, disparities between news agenda setting and epidemiology, community campaigns promoting compassion for people living with AIDS, and culture-based models of AIDS prevention.

She joined the African American AIDS Task Force (AAATF) in Gainesville, Florida, to explore church-based HIV prevention in the black community. As part of her dissertation work, she served as strategic planning consultant for AAATF and as co-chair of its public relations committee.
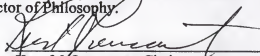
She has co-authored studies in *Health Marketing Quarterly, AIDS Education and Prevention Journal, Newspaper Research Journal,* and *Southwestern Mass Communications Journal.* Additionally, she has presented her sole-authored research at various national and international conferences, including the International Communication Association, Society for Risk Analysis, and the Association for

Education in Journalism and Mass Communication. For two years, she helped conduct a content analysis of health stories in U.S. daily newspapers as part of a Robert Wood Johnson Foundation grant.

While a doctoral student, Kristie received a college research award for her health communication work and a university teaching award for her news reporting instruction. She also taught the use of the World Wide Web in information gathering and magazine and newspaper production.
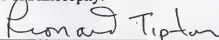
In September 1997, Kristie joined the Department of Journalism at Texas A&M University in College Station, Texas. As an assistant professor there, she teaches graduate courses in science journalism and information gathering, as well as undergraduate courses in civic journalism, computer-assisted reporting, advanced media writing, and mass communication theory. Recently she received a faculty grant to conduct a national survey of African American ministers about their attitudes concerning church-based HIV prevention initiatives. When she is not studying health communication or teaching, Kristie enjoys playing violin duets with her husband, Brent Swain, a professional violist and architecture graduate student at Texas A&M.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and in quality, as a dissertation for the degree of Doctor of Philosophy.
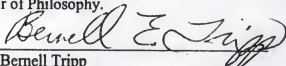
Kent M. Lancaster, Chair
Professor of Journalism and
Communications

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and in quality, as a dissertation for the degree of Doctor of Philosophy.
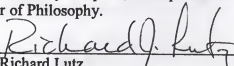
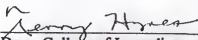Leonard Tipton
Professor of Journalism and
Communications

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and in quality, as a dissertation for the degree of Doctor of Philosophy.

Bernell Tripp
Associate Professor of Journalism and
Communications

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and in quality, as a dissertation for the degree of Doctor of Philosophy.

Richard Lutz
Professor of Marketing

This dissertation was submitted to the Graduate Faculty of the College of Journalism and Communications and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

May 1999

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